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July 13-17, 1969

Tamiment-In-The-Poconos

Volume 45 JANUARY 1969 Number 1

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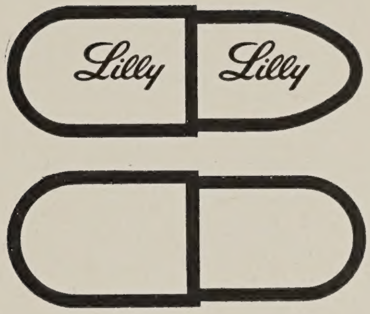

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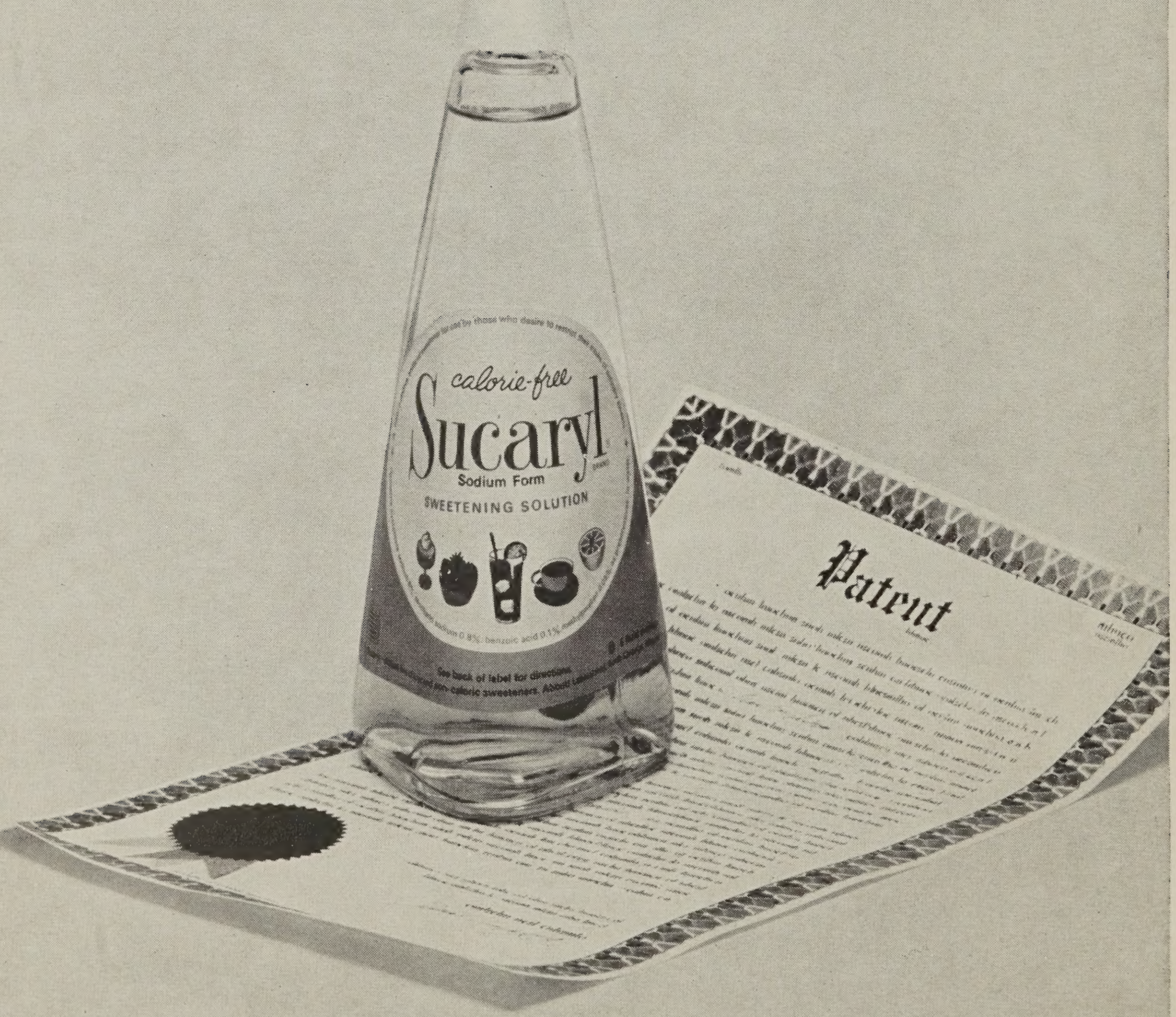
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The Maryland Pharmacist

NATHAN I. GRUZ, *Editor*

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VOLUME 45 JANUARY 1969 NUMBER 1

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Editorial . . .

GOVERNOR MARVIN MANDEL

–New Leadership for Maryland

The election by the General Assembly of Speaker of the House of Delegates, Marvin Mandel, as Governor of Maryland to fill the unexpired term of Vice President Spiro T. Agnew, ushers in a new era for the citizens of the State.

From the moment he delivered his acceptance speech, Governor Mandel clearly indicated that he intended to apply vigorous leadership and initiative to the problems of Maryland.

He assumes his high office with the reputation for proceeding in a quiet manner to effectively plan and implement legislative proposals into enactment.

The new Governor has declared that his administration will forthrightly address itself to the human problems of our citizens in a progressive manner. His first act was to restore 22,000 medically indigent persons to the Medicaid rolls from which they had been severed by the previous administration.

Governor Mandel has demonstrated in the past a sympathetic understanding of the problems facing pharmacy in its dedication to professional advancement and its commitment to provide pharmaceutical service of the highest standards to all citizens. As Speaker he supported legislation developed by the Maryland Pharmaceutical Association to enable pharmacists to more effectively govern themselves through self-regulation.

Already Governor Mandel has sought to meet contemporary problems of health in Maryland by proposing a Department of Health under a Secretary of Health to bring together all operations as well as policy-making, administrative and regulatory matters concerning health under one responsible official.

He is fully cognizant of the chaotic administration of the Medicaid Program, of the inadequate remuneration of participating pharmacies and of the need for utilization controls.

Governor Mandel also is deeply concerned with the growing drug abuse problem and is supporting enlightened measures to cope with this tragic situation.

We in pharmacy thus have valid reasons to welcome the "action" approach of the new administration to the many critical problems—fiscal, health, crime and others—facing the State.

The Maryland Pharmaceutical Association and the pharmacists of the State offer their best wishes to the Governor in his difficult and complex responsibilities. We stand ready to asist and support his endeavors in the interest of public health, welfare and safety. We trust he will call upon us for participation in all matters impinging on health and drugs and in many other areas involving the public interest.

Obituary

NELSON G. DIENER

Dr. Nelson G. Diener, Life member of the Maryland Pharmaceutical Association and President, 1949-50, died on December 24, 1968 at Union Memorial Hospital.

Dr. Diener, 78, was a graduate of the University of Maryland School of Pharmacy in 1910, receiving the degree of Doctor of Pharmacy.

He had practiced pharmacy in Baltimore and had owned pharmacies at three locations at different times. They were located at North and Druid Hill Avenues, Francis and Retreat and the last at 4817 Pimlico Road.

Dr. Diener was dedicated to his profession and to the Maryland Pharmaceutical Association. Both prior to and following his election as MPhA President, he devoted many off-duty hours to visiting pharmacies on behalf of membership and Association programs.

He was a former member of the Board of Directors of the Calvert Drug Company and an officer of the Baltimore Veteran Druggists Association. He was also a member of the Baltimore Metropolitan Pharmaceutical Association.

Dr. Diener attended Har Sinai Temple, where he was a member of its Brotherhood and was an usher for many years.

Besides his wife, Mrs. Bessie S. Diener, Dr. Diener is survived by a son, Samuel N. Diener, of White Plains, N.Y.; a brother Dr. Louis Diener of Baltimore; a sister, Mrs. Carolyn Kohner of Baltimore, and two grandchildren.

Pharmacy Calendar

April 26—Prince Georges-Montgomery County Pharmaceutical Association Annual Installation of Officers—Burn Brae Dinner and Theatre Club, Burtonsville, Md.

May 17-23—American Pharmaceutical Association Annual Meeting—Montreal. Call MPhA Office for details on group travel.

May 8—Alumni Association, School of Pharmacy Annual Meeting—Baltimore Union Building, Baltimore, 8:00 P.M.

June 4—(Wednesday) Annual Banquet, Alumni Association, School of Pharmacy, Eudowood Gardens, Baltimore.

July 13-17—87th Annual Maryland Pharmaceutical Association Convention, Tamiment-In-The-Poconos.

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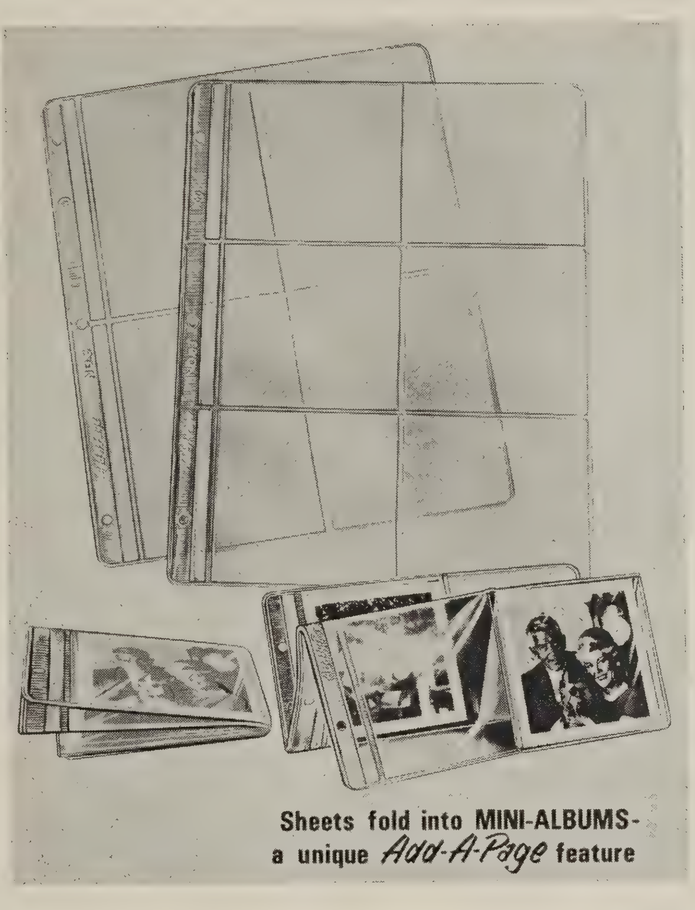

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President's Message . . .

The Maryland Pharmaceutical Association is engaged in an all out effort to enlist the participation of every pharmacist in the affairs of his profession. We have been gratified by the response so far with thirty pharmacists signed up as new members as a result of our first mailing.

Pharmacy is changing! The functions of the pharmacist in furnishing a vital element of health care will be radically different within just *five years.* Both community and hospital pharmacists are entering into revolutionary new roles. Pharmacy must become—and *is* now envolving into—a *patient-oriented* profession, not just directed toward drug products and their distribution. Pharmacy education, both undergraduate and continuing will have to prepare pharmacists for new demands.

MPhA, only with *your* membership and the support of every pharmacist, will be in a position to exert the maximum influence on pharmacy practice, education, legislation, health planning, public relations and inter-professional relations and every other area of concern.

So, get into the action! Help make the decisions for your profession which will affect you today, next year and in the years ahead.

If you have not as yet paid your dues, write your check now and mail it today. *Dues are your share of rent for the space you occupy in your profession.*

In addition, contact a colleague or associate and enroll a new member. Have the satisfaction of being part of our campaign to achieve maximum feasible strength for pharmacy in Maryland.

Finally, take advantage of the MPhA programs. Attend the meetings. Mark your calendar for the Annual Convention July 13-17 at Tamiment-in-thePoconos.

I personally look forward to your support and participation.

Samuel Wertheimer
President

ALUMNI CLASS REUNIONS

All Alumni of the University of Maryland School of Pharmacy are urged to attend the Annual Banquet on Wednesday, June 4, 1969 to honor the 1969 graduates.

Many class reunions are being planned. Contact your fellow alumni and arrange for a table or two.

Members of the Class of 1934 are requested to contact Milton A. (Mickey) Friedman for the 35th Reunion, Telephone HU 4-4686.

The Class of 1939 is planning a 30th reunion. Alvin Rosenthal and Harry Rochester may be called, Telephone 542-4837, 367-8902 or 358-0748.

APhA Convention in Montreal

Maryland pharmacists planning to attend the 1969 APhA annual meeting in Montreal, Canada, May 17-23 are urged to make their hotel reservations now through the APhA Housing Bureau, Montreal Canada.

The Bureau will make reservations only upon receipt of the form which was printed in the *APhA Newsletter* and the *Journal of the American Pharmaceutical Association.* Additional forms are available from the MPhA office.

Fourth Meeting In Canada

The meeting in the sophisticated, French-speaking metropolis will be the fourth such gathering held in Canada by the APhA in its 117-year history. Montreal, now grown to 2½ million residents, was the site of the 1896 APhA meeting, while the other two were held in Toronto in 1877 and 1932.

The APhA has planned a complete professional meeting combining informative and productive sessions in a colorful and interesting location. The meeting will open Sunday evening, May 18, in the Grand Ballroom of the Queen Elizabeth Hotel with the opening session.

Outstanding speakers and programs are planned for the General Sessions and the House of Delegates meetings during the week. The concluding annual banquet will be held Thursday evening.

Hotel Headquarters

Six hotels, all within walking distance of each other and all in downtown Montreal, comprise the accommodations planned for pharmacists and their guests. In the center of it will be the Queen Elizabeth, where APhA exhibits and registration desk will be located.

Special air travel arrangements have been made through the Singer Travel Agency, 5113 Park Heights Avenue, Baltimore, 21215, Telephone 542-6832.

An outstanding program both informational and recreational has been arranged.

Contact the MPhA Office for convention registration and hotel reservation forms.

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Secretary's Script . . .

Current Activities

During the legislative session we are involved in screening the more than 2,000 bills that are introduced in the State Senate and House of Delegates.

The State Budget and its supplements are also of great concern as the operation of the Medicaid Program is dependent upon the funds appropriated. We are hopeful for greater consideration for pharmacy services in the new fiscal year beginning July 1, 1969.

The State fiscal policies as reflected in the Executive Budget and tax bills critically affect health services as a whole, particularly Medicaid. Reimbursement to Medicaid vendors is dependent upon the rcommendations and decisions of the Health Department, Budget Department and the Governor.

Board of Pharmacy

The Legislative Committee is seeking the suggestions of members as to rules and regulations that should be considered for transmittal to the Maryland Board of Pharmacy. The Board has invited MPhA as well as all concerned individuals to advise them of suggestions which might be necessary or helpful in more effectively applying the Marland Pharmacy Laws.

MPhA Priorities

Currently MPhA is directing its attention to many of the crucial issues affecting pharmacy both in Maryland and nationally. Federal legislation and federal programs deeply affect everything we do in Maryland.

In addition, both federal and our own State officials keep an eye on developments in health programs in other states. We also have to be informed so that we can adapt desirable innovations to our own needs and be prepared with alternatives to procedures or policies inconsistent with our requirements.

In the Medicaid Program our goals are:

1. To provide pharmaceutical services of the highest standards at the lowest cost to the State.
2. To see that utilization controls and peer review are instituted to assure quality care and the best use of available funds.
3. To obtain equitable, realistic compensation for pharmacy services.
4. To do everything possible to see that the State Department of Health processes invoices for service promptly and efficiently.

   Invoices should be processed for payment as received and payment made for all prescription forms properly filled out. Discrepancies due to the inadequacies of administration in the State Department of Health or the State Department of Social Services (Welfare) should not delay payment to the vendor pharmacists.

Only by carrying out goals 2, 3 and 4 can the State and federal government expect to accomplish the first goal.

The purpose of Medicaid—to make quality health care available to the indegent and medically indegent—cannot be achieved without accomplishing this primary goal.

—Nathan I. Gruz, *Executive Secretary*

Maryland Board of Pharmacy News . . .

Pharmacy Changes

The following are pharmacy changes for the month of January:

New Pharmacies

Drug Fair 126, Milton L. Elsberg, President, 3541 Laurel, Ft. Meade Road, Laurel, Maryland 20810.

Nationwide Pharmacy Center, William A. Martin, President, 1415 Forest Drive, Annapolis, Maryland 21403.

White Cross, D. M. Robinson, President, 501 South Broadway, Baltimore, Md. 21231.

Change of Ownership

Park Avenue Pharmacy, Herbert Wienner, President (Formerly owned by Harry Glick) 1535 Park Avenue, Baltimore, Md. 21217.

Star Drug Store, Louis Eisenberg, Owner (Formerly owned by Harold H. Siegel), 5814 Belair Road, Baltimore, Maryland 21206.

No Longer Operating as Pharmacies

Metro Drug Store #3 Harold M. Goldfeder, President, 4707 Marlboro Pike, Coral Hills, Maryland 20027.

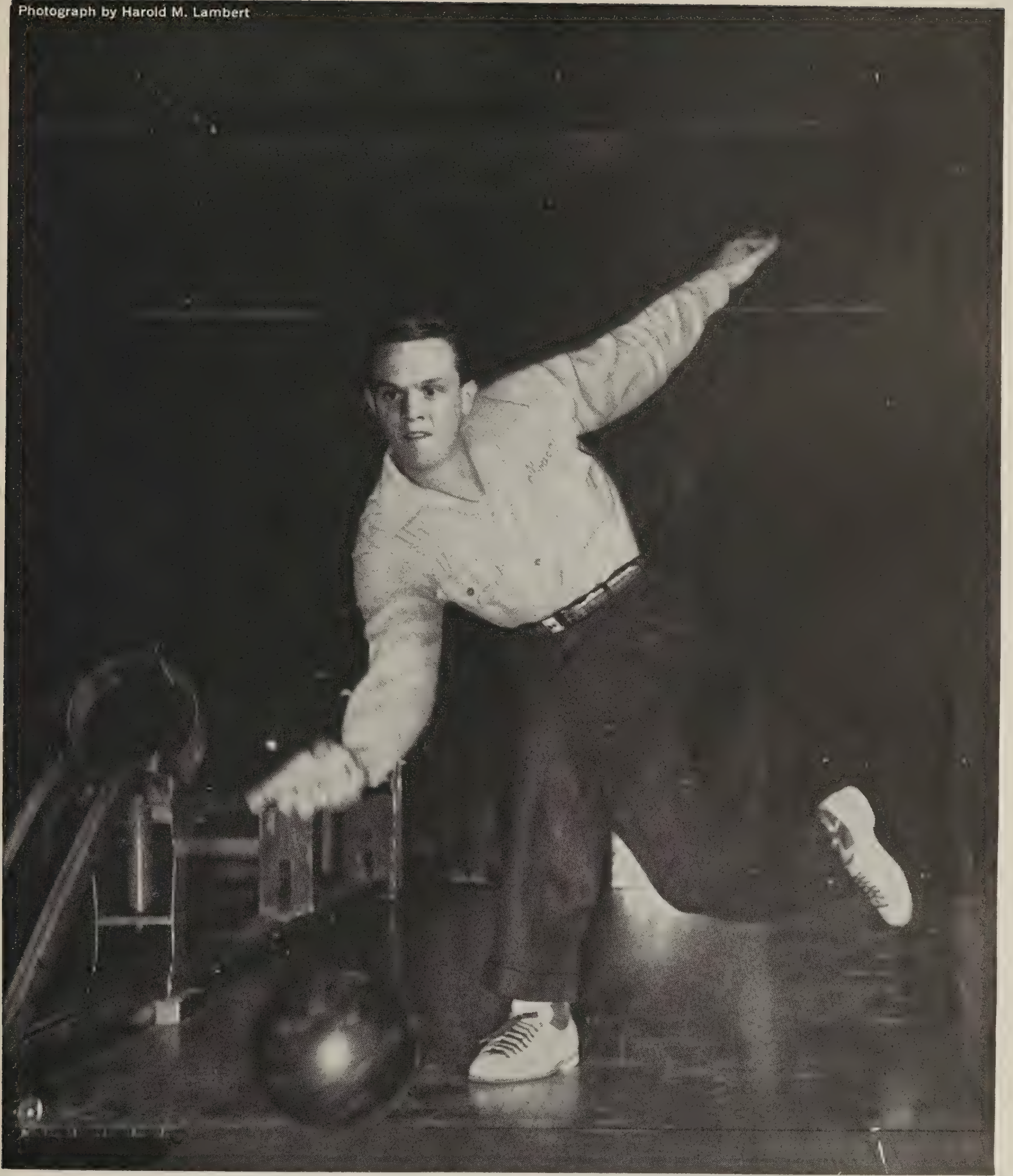
Read Drug and Chemical Company, Arthur K. Solomon, President, 919 Reisterstown Road, Baltimore 21208.

New Pharmacists Announced

The Maryland Board of Pharmacy announced that forty-eight applicants were granted registration and licensure as pharmacists following an examination conducted on October 28, 29 and 30, 1969. Their names are:

Robert W. Adams
Charles M. Alpert
Alan S. Aronson
John H. Balch
John P. Barker, Jr.
Karen Sue Blender
George C. Bohle, Jr.
Janis N. Croes
Steven C. Cohen
Steven S. Cohen
Robert W. Culler
Thomas J. Dirnberger
Wayne A. Dyke
Neil Feldman
Claude E. Foggie
Suzanne J. Gaetano
Murray P. Ginsberg
Daniel M. Gold
Jerrold J. Golob
Paula B. Graden
Robert C. Griffiths, Jr.
Patricia A. Hemmer
Arnold J. Honkofsky
Leonard C. Howard, Jr.
Lionel Harvey Jacobs
James E. Kenny, Jr.
Gary A. Lesser
Edward R. Majchrzak
Glen W. Nash
Joann L. Neuman
Elizabeth A. Newcomb
D. Wayne Parrish
Stephen A. Peck
Paul R. Pfeiffer
Uldis V. Pironis
Charles A. Priller, Jr.
John R. Ricci
Larry J. Rolf
Joseph L. Royal
William A. Smaios
Earl T. Smith
Herbert M. Sohmer
Larry P. Solomon
William Statter
Earl M. Towers
Patrick G. Welsh
Martin W. Wolff, Jr.
Leslie A. Zive

Mr. Clem Brasket passed the practical examination, but registration is withheld pending completion of the required practical pharmacy experience and examination.



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But this is just the beginning. There is more to come. And if you have any requests or ideas, please speak up. At Roche, we solicit and value your opinions. They help us to help you.

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A Campaign For Professional Advancement

The Membership Committee under Chairman Joseph U. Dorsch has inaugurated a campaign to personally reach every pharmacist in the State.

A new billing form and procedures as well as changes in the dues structure and in reciprocal membership delayed some plans. However, the campaign is now in full operation.

Drug Fair, Peoples Service Drug Stores and Read Drug & Chemical have agreed to assist in enrolling all pharmacists associated with them. Mail and personal contacts are included in this effort.

The following memorandum was mailed to every licensed pharmacist. A similar memo without the paragraphs devoted to the BMPA was sent to those outside the BMPA Area:

> At the beginning of this year, we wish to thank the members for their support and to earnestly solicit the membership of all other pharmacists and persons allied with pharmacy.
>
> Recent events have demonstrated more than ever before that pharmacy must have a strong association at the State level as well as strong local associations in every area of the State. The tremendous expansion of government into every phase of health care, which is having an almost overwhelming impact upon pharmacy practice, especially requires organized representation.
>
> During the past year, we have been extremely active in legislative matters and devoted a great deal of time and effort and expense in the fields of Medicaid and OEO Comprehensive Neighborhood Health Centers.
>
> As to the OEO, we have succeeded over great odds in achieving a pioneering agreement for a pilot vendor pharmacy program. This will enable the private sector to demonstrate it can meet the pharmacy needs of the poor—an issue of vital importance to the future of community pharmacy.
>
> In the case of Medicaid, the original cut of the pharmacy fee was to $1.15. Although we were not successful in a complete restoration, the Governor modified the fee to $1.25. Our efforts are still continuing, with our request for at least $1.75 already approved by the State Department of Health for July and now dependent upon the Governor's budget. We must emphasize that Association efforts did produce increases in the fee in the *three* previous consecutive years. We are engaged in vigorous efforts to improve the administration and payment procedure. A new procedure will go into effect to meet many of the problems and burdens of participating pharmacies.
>
> In addition, a landmark Physician/Pharmacist Code of Cooperation has been adopted by both professions. Our work in Continuing Education resulted in the successful conclusion of the first program, cosponsored with the School of Pharmacy.
>
> Last year, the Baltimore Metropolitan Pharmaceutical Association voted to change its organization to a pharmacists' association. Every pharmacist is eligible for full, active, voting membership regardless of whether he is a proprietor or salaried. Also, a reciprocal membership agreement was reached between MPhA and BMPA, calling for a single dues. The enclosed combined dues billing is aimed at producing the strong membership and organizational structure that pharmacists desire, recognize as essential and now demand.
>
> In order to effectively perform the tasks you demand of the MPhA and BMPA, it is absolutely essential to do away with duplication and competitiveness that is not constructive.
>
> MPhA and BMPA work for the benefit of all associated with pharmacy and so "Sustaining Membership" has been set up for suppliers of pharmacies in place of requests for support during each year.
>
> Let us all work and strive together toward the goals we seek—better health for all through a constantly advancing profession of pharmacy.
>
> Your prompt remittance of your dues in the postpaid envelope will demonstrate your commitment to your profession and help assure our progress during the coming year.
>
> An attractive, distinctive certificate of membership in your professional group which you will be proud to display is awaiting 1969 members.

Chairman Dorsch has set up Chairmen in every area of the State to organize local Membership Committees to personally contact every pharmacist who has not responded to two dues bill mailings.

DEPARTMENT OF
HEALTH, EDUCATION AND WELFARE
CHARLOTTESVILLE, VIRGINIA

Office of the
Regional Director

Region III
Virgin Islands

January 30, 1969

Dear Mr. Gruz:

Former Secretary Cohen and I wish to express to you our sincere appreciation for your valuable contribution to the Medicaid Hearings on December 23 and 30, 1968.
A copy of the proceedings is enclosed for your information.

Sincerely yours,

/sgd./
Bernard V. McCusty
Regional Director

Mr. Nathan I. Gruz
Executive Director
Maryland Pharmaceutical Association
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AS I SEE IT
STM '68

Samuel L. Fox, Ph.G., M.D.

Lighting and Eyestrain

There are many common myths about the effects of dim lighting upon the eyes. Much of this has grown up in the manner of "old wives' tales" and has little or no scientific basis. Dr. David Cogan, Director of the Howe Laboratory of Ophthalmology, and Professor of Ophthalmology at Harvard University, recently published a paper entitled. "Lighting, Eyestrain, and Health Hazards," in the *Sight Saving Review* issued during the summer of 1968. More than 25 years ago Dr. Cogan became interested in the problem because of the "sort of mystique on the alleged health hazards of low illumination." As an ophthalmologist he felt he had an obligation to determine the ill effects of such low illumination in order to bring proper warning to the public or to dispel the common myth if there were no health hazard. In this paper Dr. Cogan reports the results of his quarter century of studies and investigations, and I shall quote liberally from it.

As late as 1948 a recognized engineering handbook, the "IES Lighting Handbook,"admonished that eye defectiveness from grade to grade among school children "might be due to the performance of visual tasks of inherently low candle levels . . . might be helpful . . . in reducing the visibility under relatively poor lighting and seeing conditions which have commonly prevailed." The handbook adds: "There is adequate encouragement that higher foot-degree and prevalence of eye defectiveness." It recommends 1,000 footcandles for optimum brightness.

Low Illumination Effects

This preoccupation with damage to the eyes by low illumination continues today among lighting engineers and architects despite the lack of adequate scientific evidence that this is so. A recent article by Logan ("The Relationship of Light to Health" published in Illum. Eng 62:159-167, 1967) states that hygienic lighting levels maximize at upwards of 2,500 footcandles and operation at lower levels results in relatively poor health and short life expectancy. Cogan points out the preposterousness of this statement.

It is generally believed, by laymen and professionals alike, that reading in poor light gives one eyestrain. But just what do we mean by "eyestrain"? Cogan defines eyestrain as "a state of fatigue resulting from use of the eyes." It increases proportionately with the difficulty of the visual task. Common causes of eyestrain are prolonged reading of small print, reading under excessively low illumination, and reading under glareful conditions or in the presence of distracting noises or even distracting thoughts. This so-called eyestrain is a fatigue of mental concentration and in no way poses a threat to the eyes. It is no different from the fatigue which results from concentrating on a lecture delivered in scarcely audible tones or in the presence of competitive sounds or other distractions.

Eyestrain Defined

The term "eyestrain" is therefore confusing and misleading. After more than 25 years of studying the problem, Cogan's conclusions are these: "Prolonged visual effort may be fatiguing, and low illumination may contribute to this fatigue by making the visual task more difficult, as do glare, environmental distractions, and even personal temperament. Visual efforts may be exhausting and may contribute significantly to a state of irritability or emotional instability, but there is no evidence that they cause myopia, glaucoma, cataracts, or any other eye defectiveness."

Dr. Cogan further advises that "if eyestrain reflects the difficulty of concentrating on a visual task, the way to avoid it is to be comfortable, and this is a matter of individual personal evaluation. In arrivng at a judgment on the amount of desired light, one does not need a meter rule or an absolute rule any more than one needs an indicator to tell him how loudly he likes his radio or how hot his bath water should be. In reading I personally find 10 to 20 footcandles adequate and 100 footcandles uncomfortable. Reading in sunlight or highly reflected sky light is downright painful. Eyestrain, in the vague sense that it is commonly used, increases for me with higher levels of illumination."

High Illumination Effects

The assumption of the lighting engineers, educators and psychologists who have been responsible for encouraging the use of higher levels of illumination in schools, factories, libraries and homes is that such levels of high illumination could not be harmful to the eyes because of some built-in body defense mechanism which would protect the eyes to any level of illumination to which it might be ordinarily exposed. Recent scientific studies suggest that this may not be the case, and that high levels of illumination and continuous exposure of the eyes to illumination may lead to serious visual damage.

The first suggestion of this appeared as a brief note in 1955 in *Science* which described an enlargement of the eyes of chicks exposed to continuous illumination, associated with thinning of the retina. More recently Werner Noell (of Buffalo) and John Dowling (of Baltimore) and Toichiro Kuwabara (of Boston) confirmed that rats continuously exposed to light became blind. The amount of light necessary to blind the rats is not excessive in comparison to some lighting recommendations. Similar changes occur in rabbits and monkeys but are less marked.

Intensity Effects

Cogan concludes that "the clear implication is that we must take care in recommending ever more intense and prolonged lighting lest we cause organic harm to the eyes. It is too early to quantitate this for man and to prescribe

(*Continued on page* 19)

Eastern Shore Pharmaceutical Society

EASTERN SHORE PHARMACEUTICAL SOCIETY—Officers 1969

Left to right: Thomas M. Payne, Treasurer; William P. Smith, Secretary; Charles W. Bennett, Jr., Honorary President; I. Earl Kerpelman, President-elect; MPhA; James W. Truitt, Jr., President; Philip D. Lindeman, First Vice President; Gordon M. Harrison, Second Vice President and Wilmer (Happy) Parker, Chaplain.

The ladies who make the Eastern Pharmaceutical group a "Society".

Photos by Paramount Photo Service

The Eastern Shore Pharmaceutical Society met on January 19th at the Holiday Inn, Salisbury, Maryland and elected officers for 1969.

Addressing the meeting was Mr. John R. Shaheen, Executive Director, Blood Bank of the Eastern Shore, Inc. Mr. Shaheen described the work of the non-profit organization which operates as a service agency on an insurance principle. It is a "neighbor-helping-neighbor" plan which assures its members of all the whole blood that may be needed.

James W. Truitt, Jr. of Federalsburg (left) incoming President receives gavel from immediate Past-President, Charles W. Bennett, Jr., of Salisbury.

AS I SEE IT

(*Continued from page* 18)

safe limits. Levels of 1,000 footcandles would certainly appear to be hazardous for continuous illumination."

Although low illumination makes a visual task difficult (and therefore contributes to psychologic fatigue), it is not implicated as the cause of some ill-defined damage to the eyes. In contrast to the relative inocuousness of low illumination, recent evidence points to ocular hazards from high levels of continuous illumination and suggests that some of the currently recommended levels of artificial lighting approach the hazardous level.

Comfort—The Criterion

The ideal level of illumination is not yet established. Nevertheless, Cogan feels that "it would seem reasonable to recommend illumination in excess of 100 footcandles with caution. *The best criterion for adequate illumination is probably comfort,* and this is a personal matter in which the opinions of architects, engineers, physicians, and laymen have equal validity."

It might be pointed out that the request for tinted eyeglasses is ever on the increase in exact proportion as workers are subjected to increased illumination in their working environment. This would tend to corroborate Cogan's findings that excessive illumination is not comfortable nor well tolerated.

Pharmacy Services under the Maryland Medicaid Program

Nathan I. Gruz

In this testimony presented at a hearing conducted by the Department of Health, Education and Welfare in Washington, D.C. on December 30, 1968, on methods of improving the Medicaid Program, the Executive Secretary of the Maryland Pharmaceutical Association points out the necessity for proper administration and equitable compensation to vendors.

Both are essential to maximum vendor cooperation and participation. In order to assure the highest possible quality of health care and maximum return from funds expended, a program of utilization controls and a formulary must be established.

Under current operating policies and practices, the Maryland program is in violation of Federal guidelines and may jeopardize continuation of Federal matching funds.

My name is Nathan I. Gruz and I am the Executive Secretary of the Maryland Pharmaceutical Association. I appreciate your invitation to present my views as to how the Medicaid Program can be improved.

I will confine my comments to several areas which have been of great concern to the pharmacists participating in the program. The overwhelming majority of the pharmacists are participating and desire to continue to participate contingent upon the satisfactory resolution of a number of issues.

Pharmaceutical services must continue to be readily available to ambulatory Medicaid patients in their communities and neighborhoods of residence. It is important to the dignity of the individual for him to be able to patronize the pharmacy of his choice when in need of medication.

In Maryland, the unsatisfactory system of processing and payment of invoices, coupled with a fee for pharmaceutical services which is in violation of the official Federal policies, threatens the maintenance of the current widespread availability of participating pharmacies.

The fee for pharmacy services in Maryland was reduced July 1, 1968 from $1.50 to $1.25. A survey of Maryland pharmacies indicated that the average fee for private patrons is $1.91. The Blue Cross Pharmacy Plan has set the fee in Maryland at $1.85 and Military Medicare (CHAMPUS) has established a $1.75 fee. These latter two fees were computed after thorough analysis and cost accounting studies.

Section D-5144 of Supplement D of the Handbook of Public Assistance Administration (6-17-66) calls for "realistic schedules of compensation for services, which should be commensurate with 'reasonable cost' or 'reasonable charge' and not inconsistent with prevailing community payments, such as under Title XVIII or Blue Shield Plans."

Section D-5320 requires that "fee structures will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care services included in the plan at least to the extent these are available to the general population."

D-5330 states as one criterion in administration of the State Plan that "Eligible persons are not forced to travel outside their communities to receive medical care and services of the types available to others within their communities," In addition, this section requires, "Participating practitioners include sufficient members of each profession, and a proportionate number of practitioners qualified for specialty practice within professions, so that the items of medical care and services included in the plan are available to eligible persons at least to the extent they are available to the general population. As a minimum, the participation ratio determined separately for each profession, and for specialities within a profession, should be approximately two-thirds of such practitioners in the State."

We have pointed out these requirements to the Secretary of the Department of Health, Education and Welfare. In a conference with Dr. Francis L. Land, Commissioner of the Medical Services Administration, in July 1968, we presented this information. We pointed out that a continuation of the existing situation would result in numbers of pharmacists curtailing their services to Medicaid patients or dropping out of the program entirely.

The response to us has been that unless a "crisis" developed in the program, the Federal Authorities would not intervene.

Certainly some initiative or action by Federal Authorities could contribute constructively to the resolution of these kinds of problems. I do not believe it was the intention of Congress that the poor or medically needy should suffer before there was Federal intervention in a program involving substantial Federal matching funds.

After many conferences with state executives and health officials, the Maryland Pharmaceutical Association has recommended that pharmacists seek the cooperation of physicians in their areas to reduce the quantity of medication prescribed at any given time consistent with good medical practice and the health needs of the patient. We have emphasized at the same time that no person should be denied medication when needed and that the recommendation did not apply to antibiotics and other life-saving drugs. The intent was to reduce the tremendous amount of money due pharmacists at any one time and at the same time to dramatize the plight of the pharmacist who has been expected to provide service at below his cost of operation.

We believe also that the Medicaid Program has been operating primarily as a money paying mechanism and that insufficient attention has been given to what is being purchased.

There is critical need—and we have been urging this for a long time—for a vigorous system of assuring quality care and for an on-going program of utilization control combined with a formulary. We believe that substantial savings can be realized by establishing review mechanisms both at the State agency level and by peer groups.

Federal guidelines for quality assurance and utilization control should be developed in some detail. The methods and results found in other states to be effective in these problem areas and in the matter of general state administration, invoice processing and payment procedure should be made available to all.

A disturbing change in Federal policy was the change in Section D-5150 announced by Social and Rehabilitation Service Administrator Mary E. Switzer, permitting physicians to obtain reimbursement for drugs dispensed by physicians.

There has certainly been more than adequate testimony before Senator Hart's Subcommittee on Anti-Trust and Monopoly to convince objective observers that the interest of the patient is best served where the prescriber of medication is not the same as the dispenser. Possible patient needs were best met under the previous Federal policy which permitted Federal financial participation for drugs dispensed by prescribers only "where no adequate pharmacy services exist or are available when needed."

We strongly urge that in order to remove a possible source of difficulty for patients, prescribers and the program, that Section D-5150 be restored to its original wording.

The current status of the program in Maryland has caused some pharmacists to modify their service to Medicaid beneficiaries. A growing number are dropping out of the program, thereby requiring some patients to travel some distance for service.

Thus we see Medicaid patients reaping the harvest of less than the first-class treatment envisaged in the Medicaid legislation. We want Medicaid patients to receive the benefits of pharmacy service from a pharmacy of their choice, not just from some pharmacies.

The convenience of a neighborhood community pharmacist, located in proximity to the patient, accompanied by the beneficial personal relationship between the pharmacist and his patron in a normal setting, is important in effecting maximum cooperation from the patient and his family. Obtaining medication and maintaining a prescribed regimen without loss of continuity is more likely under these conditions. Most community pharmacies are open long hours, seven days a week. The importance of an easily reached pharmacy in obtaining prescription refills cannot be stressed too strongly.

Pick up and delivery of prescriptions is also vitally important for the aged, the infirm, or persons living alone, and for families with infants and children when a parent cannot leave the home.

The increasing number of pharmacists who are establishing patient medication record cards is another vital reason for each patient to choose a "family pharmacist" and obtain pharmaceutical services solely from this one pharmacist under normal circumstances. Procuring medication from one pharmacy where such records are maintained contributes significantly to more effective medical care. The individual medication record contains information as to drug allergies and idiosyncrasies. It permits ready surveillance of fidelity to prescribers' instructions through revealing frequency of refills or repeats of prescription and non-prescription drugs. Often patients will visit more than one physician who unknown to each other will be prescribing the same or similarly acting drugs with possible danger to the patient.

We must stress that there are implications for patients, prescribers, the program and the profession of pharmacy when some pharmacies become unavailable to Medicare patients due to non-participation because of unsatisfactory program administration and inequitable compensation. Many eligible persons are deprived of the pharmacy of their choice. The opportunity for the voluntary relationship based upon the personalized interest of the neighborhood pharmacist and the resulting benefits should not be taken away from poor people.

The apparently satisfactory experience of the Maryland Blue Cross in serving as fiscal intermediary for Medicare requires us to explore this avenue thoroughly. The final decision must rest on a comparison of cost factors, the time lead necessary for implementation by Blue Cross of a claim processing and payment system and the capability for assuring quality performance by vendors and operation of utilization controls.

We would like to suggest also that in computing the Federal share of funds for a state, consideration be given to financial incentives for the establishment and maintenance of the superior standards of service, rather than merely to hold the threat of suspending funds as a punitive measure for non-conformance.

We wish to thank you for this opportunity to present our views and stand willing to cooperate with all those involved in securing health care for all.

Thank you.

As a rule, the most successful man in life is the one with the most information. —*Benjamin Disraeli*

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MUTUAL FOCUSING

University of Maryland School of Pharmacy

Senior Class News

by John Motsko

Upon returning for the Fall Semester, we were pleased to see a new administration filled with new ideas, curriculum, and faculty. The presence of Dean William J. Kinnard, Jr., has encouraged a new atmosphere around Dunning Hall. Student-faculty relationships have hit an all-time high, and there seems to be a great willingness to get things done. Although the Senior Class will not benefit from all the changes, this new outlook will definitely help encourage recent graduates to attend the Continuing Education Programs.

Even with the improved environment around school, June can't come too seen for the Seniors! Most of us are looking forward to the time when we will, at long last, see the rewards of our five years in school. However, in the meantime, we have been busy both academically and socially.

The Class was pleased to attend the Fall Meeting of the Maryland Pharmaceutical Association in October, and hopes that the pharmaceutical associations will continue to encourage the Seniors and student body to join and participate in their programs. The Fall Frolic, sponsored by the Alumni Association, was a great success. A crowd of nearly three hundred, including most of the faculty, had a most enjoyable time.

Plans are now being formulated for the Senior Prom which will be held following the Alumni Banquet on June 4th. This is an attempt to streamline the Graduation Week Program for the Seniors. We hope the banquet will encourage more graduates of the School to participate in the Alumni Association.

Skit Night, formerly a command performance presented by the school will be presented by the Senior Class sometime near the end of the school year. We are sure the event will be a success. Invitations will be extended to the Alumni.

The Dean has informed us that our trip to Eli Lilly and Company will be somewhat different from previous tours. As Dean Kinnard considers this an important part of our education, the visit will take place during the school year and not during the semester break as has been done prior to this time. The Class will fly to Indianapolis, and pass up the "pleasurable seventeen hour train ride." Needless to say, we are looking forward to the trip which will take place this Spring.

With little time remaining in our final year, and much to accomplish, we must return to the Academic World. We trust that the Alumni Association and the Maryland Pharmaceutical Association will continue to support Dean Kinnard in his plans for the future of the school and the profession.

Prince Georges–Montgomery County Pharmaceutical Association

Photo by Paramount Photo Service

Left to right: Ervin M. Koch, President; Detective Sergeant R. R. Bowers and Paul Reznek, Secretary.

Detective Sargeant R. R. Bowers of the Juvenile Division Montgomery County Police Department discussed "The Teenager" at the Prince Georges-Montgomery County Pharmaceutical Association General Membership Meeting, Thursday, January 16, 1969.

Our days are all the same size, like identical suitcases. But some people can pack more into them than others.

One of the things to be thankful for is that we don't get as much government as we pay for.

—*Charles F. Kettering*

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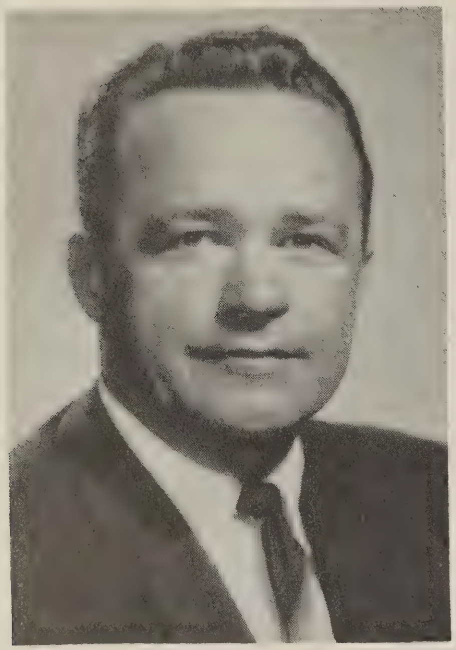

L. SCOTT GRAUEL
Honorary President
T.A.M.P.A.

L. Scott Grauel, Honorary President of the Travelers Auxiliary of the Maryland Pharmaceutical Association for 1969 joined the Henry B. Gilpin Company in 1951 after engaging in a diversified career in community pharmacy, wholesale drug distribution and as a laboratory representative.

He is a Past President of the Commercial Auxiliary of the Virginia Pharmaceutical Association, Charter Member of the Suburban Kiwanis Club, Associate Member of the American Pharmaceutical Association, member of the Baltimore Sales and Marketing Executives Club and a member of the Baltimore County Planning Board.

Mr. Grauel and his wife Pattie, with their two daughters, reside in Baltimore County.

TAMPA Notes

Arnold E. Wells is now associated with Kerry Glass Container Corporation, which has been purchased by the Packaged Materials Division of Armstrong Cork Company, his former employer.

Nathan Schwartz Honored

Nathan Schwartz of Annapolis, member of the MPhA executive committee, has accepted the post of Israel Bond Chairman for Knesseth Israel Congregation, Annapolis.

Mr. Schwartz and his committee will spearhead an intensified drive to provide increased funds for economic development as Israel strives to achieve a just and lasting peace with her Arab neighbors.

B. DORSEY BOYLE
Honorary President
B.M.P.A.

B. Dorsey Boyle was installed as the Honorary President of the Baltimore Metropolitan Pharmaceutical Association for 1969 at the 53rd Annual Dinner Dance and Installation of the Association.

In 1967, Mr. Boyle was Honorary President of the Traveler's Auxiliary of the Maryland Pharmaceutical Association (TAMPA). He is the only man to have been honored by both groups.

A native Marylander, born in Libertytown in the year 1905, he received his education at Mt. St. Mary's Preparatory School, Mt. St. Mary's College and the Wharton School of Finance, University of Pennsylvania. He is married to the former Margaret Carlin and they have two daughters, Mrs. Clark J. Minter of Morristown, N.J. and Mrs. William Middleton Porter of Potomac, Maryland and two grandchildren.

He is presently Regional Staff Assistant for the Coca Cola Company in Baltimore, rounding out forty years with the company. He began working for Coca Cola in Atlanta in 1929. Through the years he has been working with pharmacists through the New England and Mid-Atlantic States, assuming the responsibility of Regional Staff Assistant in 1967.

Mr. Boyle is a member of the congregation of the Cathedral of Mary Our Queen on Charles Street in Baltimore and very active in various church affiliated work. He is a member of the Rotary Club of Baltimore, the Advertising Club of Baltimore, the Delaware Restaurant Association, on the Board of Directors of the Maryland Restaurant Association, the Baltimore Area Convention and Visitors Council, Inc., Delaware Travelers Association of the Delaware Pharmaceutical Society. He was named "Purveyor of the Year" of the Restaurant Association of Maryland in 1960 and since 1964 has served as Chairman of the Restaurant Division of the March of Dimes.

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Baltimore's Mayor D'Alesandro Recipient of MPhA Service Award

Remarks of Nathan I. Gruz, Executive Director Baltimore Metropolitan Pharmaceutical Association and Executive Secretary of Maryland Pharmaceutical Association, presenting a "Distinguished Service Award" to Mayor Thomas J. D'Alesandro, III at the Installation Banquet of the Baltimore Metropolitan Pharmaceutical Association, Sunday, January 26, 1969 at Emerald Gardens.

In America today—as it has been for the past few years—we find that the action is in our big cities. *Our greatest domestic problems and our toughest domestic challenges are associated with the urban crisis.*

Our municipal governments have the primary responsibility to face up to and attempt to cope with seemingly insoluable dilemmas of the human condition and the environmental factors impinging upon it. We have been fortunate in Baltimore to have elected to be under the guidance of a young, dynamic leader such as our honored guest, Mayor Thomas J. D'Alesandro, III.

In a short period of time this dedicated public servant demonstrated his commitment to the welfare of the totality of our community. That is why the Maryland Pharmaceutical Association last year selected him as the first recipient of its Distinguished Service Award together with his colleague, William Donald Schaefer, President of the Baltimore City Council. Unfortunately he could not be present at the 1968 Annual Convention to receive his award.

Tonight it is our distinct honor to personally recognize and pay tribute to the Mayor, whose record has been truly "A Profile in Courage." Mayor D'Alesandro has been concerned with not only the disadvantaged citizens of the community, but at the same time has recognized the vital role of the professional and business sector in the well being of the City.

He is convinced that wherever possible existing resources of the private sector should be given every opportunity to be utilized. His position has been:

> Government sponsored facilities should not be established which would duplicate, replace or possibly damage private providers of health services in target areas of governmental programs.

The support and assistance of Mayor D'Alesandro goes back to the period when he served as President of the City Council. It took great courage during his political campaign to back the principle of "free choice" of pharmacy in a proposed OEO program.

His position is recognized and best summarized in the Report to the Select Committee on Small Business of the House of Representatives by Congressman John D. Dingell, Chairman of the Subcommittee on Regulatory Agencies. Its hearings on the "Impact of the Neighborhood Health Centers Upon Small Pharmacies" were devoted almost exclusively to the Baltimore situation. The highlights of the testimony were arranged by the Officers and Staff of your State and local Associations, along with our very able counsel, Joseph Kaufman.

Mayor D'Alesandro, the report released just this past week, stated, ". . . supports the position that a limited service pharmacy under the supervision of a licensed pharmacist should be established in the center but only to meet the 'inhouse' or 'on site' requirements. The Mayor further supports the position that prescriptions should be filled or compounded at community pharmacies of the patient's choice in accordance with a vendor system. The mayor concluded by expressing the hope that an acceptable compromise can be obtained so that the Provident Comprehensive Health Center can move forward."

As a result, a compromise has been worked out and we trust will be implemented expeditiously. The crucial importance to the entire profession of pharmacy nationwide of what the Maryland and Baltimore Metropolitan Pharmaceutical Associations have been able to accomplish with the critical support of the Mayor, President of the City Council and members of the City Council, is demonstrated by the conclusions and recommendations of the Congressional Committee Report.

The Committee concluded: "In view of the (hearings) it must be questioned whether neighborhood health centers should be dispensing drugs unless a clear showing is made for so doing."

The Committee recommended: ". . . that hereafter when OEO is requested, by local groups of pharmacists and associations of such pharmacists, to meet and confer concerning proposed or existing neighborhood health centers, that the appropriate officials of the agency confer in good faith and take all steps appropriate or necessary to insure maximum appropriate participation by small business retail pharmacies in any program administered by OEO."

And so we see by this vivid illustration the fruits of aggressive organized efforts when made effective by the wise understanding and vigorous action of our Mayor.

That is why we are delighted and proud to honor Mayor Thomas J. D'Alesandro with this "Distinguished Service Award for Devotion to Civic and Community Service" presented on behalf of all pharmacists by the Maryland Pharmaceutical Association. It is a small token of appreciation by the pharmacists of the City and the entire State for the support he gave to citizens concerned with both the general welfare and interest of their professional survival.

A Professional Service Message

Never before in pharmaceutical history, has there been a greater need for pharmacists to band closer together for their mutual benefit, and yet, local, county and state organizations are suffering from a lack of interest on the part of pharmacists.

Only with active participation on the part of all pharmacists can your associations begin to cope with the many and varied problems, that are confronting pharmacy today.

Attendance at meetings, working on committees, constantly being on the alert for proposed legislative changes, that can affect your business and professional life, is a necessity as well as the duty of each and every pharmacist.

We urge every pharmacist to join the local and state organization, attend as many meetings as possible, keep current, make yourself heard, and help shape the future destiny of your chosen profession.

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Baltimore Metropolitan Pharmaceutical Association

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Left to right: Nathan I. Gruz, Secretary and Executive Director; B. Dorsey Boyle, Honorary President; George J. Stiffman, Vice President; Anthony G. Padussis, President-elect; Bernard B. Lachman, President; Joseph L. Okrasinski, Vice President; Irvin Kamenetz, Vice President; Donald O. Fedder, Chairman, Executive Committee; Charles E. Spigelmire, Treasurer.

BERNARD B. LACHMAN
President
B.M.P.A.

Bernard B. Lachman, President of the Baltimore Metropolitan Pharmaceutical Association for 1969 has a record of deep involvement and accomplishment in the affairs of pharmacy on both local and State levels.

His early experiences in association work were on the Public Relations Committee. He has since served in practically every area of association work including MPhA Health and Welfare Committee, Budget and Finance, Legislative, and, of course, as a member of the Executive Committee of both MPhA and BMPA and as an officer. For two years he was Chairman of the BMPA Mid-Atlantic Drug and Cosmetic Show.

President Lachman has served since 1966 as Chairman of one of the key committees in the Maryland Pharmaceutical Association, the Legislative Committee. It was under his chairmanship that one of the most far-reaching legislative programs sponsored by the MPhA was enacted in 1967. The new law defines the "practice of pharmacy" for the first time and revises the definition of what a "pharmacy" is. In addition, the law grants authority to the Board of Pharmacy to promulgate rules and regulations regarding the practice of pharmacy, including the promotion and advertising of professional services.

When the University of Maryland School of Pharmacy recently set up study committees to revise the curriculum, President Lachman was appointed Chairman of the Committee on Community Practice.

In addition, he serves on the Pharmacy Services Committee of the State Medical Assistance (Medicaid) Advisory Committee.

Mr. Lachman was an organizer of PHARMPAC (Pharmacists' Political Action Committee), which he serves as treasurer. He holds membership in the APHA, NARD and the Alumni Association of the University of Maryland School of Pharmacy.

"Bunky", as many of his friends refer to him, operates two community pharmacies in partnership with his brother, Marc Lachman. One pharmacy is in the Pimlico area of Baltimore, the other in Chartley near Reisterstown.

Mr. Lachman is a native Baltimorean, a graduate of Forest Park High School and the University of Maryland, receiving a B.S. in 1945. He is married to the former Selma Berdiansky and is the father of three children, Diane, Larry and Jan.

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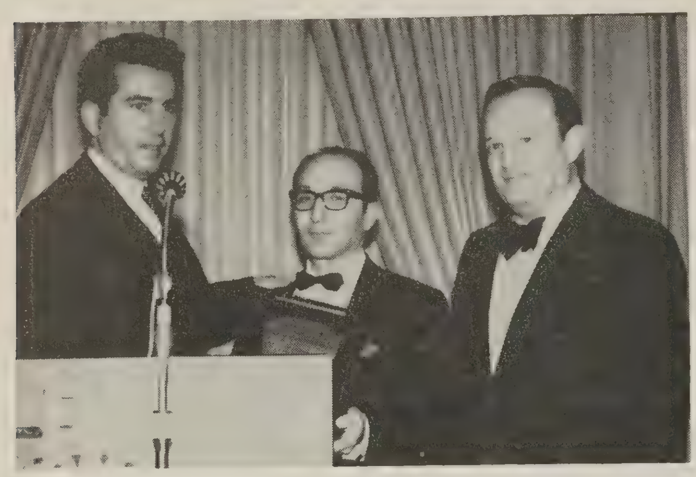

Baltimore Mayor Thomas J. D'Alesandro, III (left) recives a "Distinguished Service Award for Devotion to Civic and Community Service" presented by BMPA and MPhA Executive Secretary, Nathan I. Gruz, on behalf of the Maryland Pharmaceutical Association. BMPA President Bernard B. Lachman is on right.

EMERALD
GARDENS

President Lachman (right) receives gavel of office from outgoing President, Donald O. Fedder.

Mayor D'Alesandro (right) with President and Mrs. Bernard B. Lachman.

EMERALD
GARDENS

Honorary President, B. Dorsey Boyle (left) awarded plaque in appreciation for his service to pharmacy, from President Lachman.

Donald O. Fedder, 1968 BMPA President awarded AZO Fraternity's "Order of the Double Star" for "Achievement in Association Work in Pharmacy".

Photos by Paramount Photo Service

Holdup and Burglary Reports

Pharmacists should exercise extreme caution and discretion in divulging information regarding losses suffered in holdups or burglaries.

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1882

the maryland pharmacist

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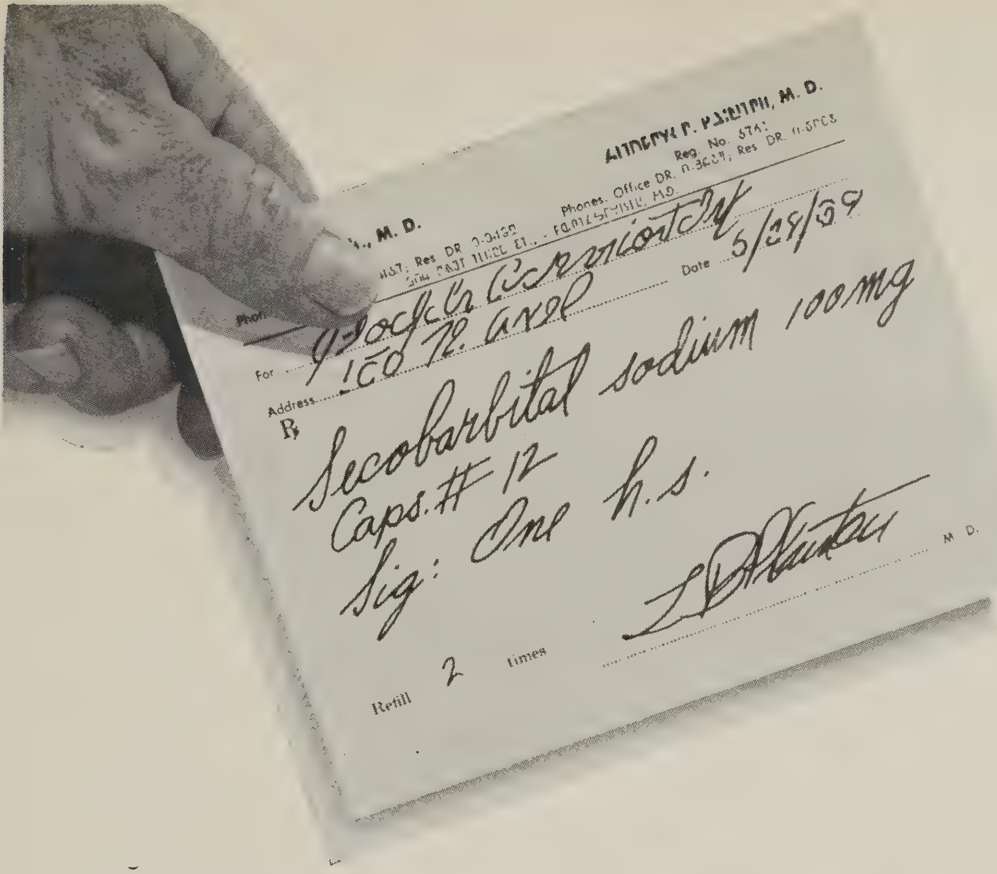

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The Maryland Pharmacist

NATHAN I. GRUZ, *Editor*

650 WEST LOMBARD STREET BALTIMORE, MARYLAND 21201

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VOLUME 45 FEBRUARY 1969 NUMBER 2

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Editorial . . .

The Medicaid Program

The Maryland Medical Assistance Program (Medicaid) is an implementation of Title 19 of the Federal Social Security Amendments. The law was designed to meet the medical needs of the indigent and the medically indigent in a joint program with federal and state funds under federal guidelines, state administration and local governmental eligibility certification and other limited responsibilities.

We in pharmacy have been working hard since the inception of the original "medical care program" twenty years ago as well as under "Medicaid" since July 1966 to make the system work for the benefit of the patients who are covered under the law.

We have struggled to establish policies that will be fair to patients, providers of service and the government. We have called for utilization controls and supported proposals to assure the best quality of care at the lowest possible cost.

As there are in every field, we have had a few in our ranks who have not abided by the requirements of the program. Some have been alleged to be in collusion with other providers at the expense of the program.

The Maryland Pharmaceutical Association reasserts its position:

1. To support a system that will assure high standards of health care for all citizens as economically and effectively as possible.
2. To cooperate in eliminating abuses by providers of service. We urge the implementation of utilization review, the encouragement of rational prescribing, the use of peer review and field representatives.

It is incumbent on every pharmacist to scrupulously abide by the Medicaid laws and regulations. We call upon them to report abuses by any patient or any provider of service, pharmacist or other.

As health professionals in a free society, we must spare no effort to assure the integrity of the private sector in providing health care services to governmental, third-party or any other system of medical care.

President's Message . . .

One of the main keys to success of this or any organization's strength is membership. There are still far too many pharmacists who benefit from the efforts of the Maryland Pharmaceutical Association but who are not members.

So far we have had an excellent response in the Baltimore Metropolitan Area from both owner and staff pharmacists in supporting the reciprocal membership and dues structure. The response has been far above our projections.

Now that the Allegany-Garrett County Pharmaceutical Association, BMPA and Eastern Shore Pharmaceutical Association require MPhA membership, it is our hope that all other groups will follow suit. Under Membership Chairman, Joseph U. Dorsch, a personal contact membership campaign is under way. The major drug chains are assisting in the drive as well as in sharing in the payment of dues.

Greater numbers will give us greater strength—in staff, in finances, and in influence. This is essential if we are to make a strong impact on government, in politics, on other professions and the public.

Is every pharmacist you are associated with sharing the load of supporting the state professional society of all pharmacists?

In the meantime, I urge you to make every effort to attend the functions of the MPhA and the Annual Convention. Thus you can share in your profession's decisions.

Samuel Wertheimer, President

From the President of LAMPA

Invite Your Friends to Become L. A. M. P. A. Members

The success of the Ladies Auxiliary of the Maryland Pharmaceutical Association depends on the interest and enthusiasm of our members who inspire their friends to join in the organization.

It has been in this spirit, that all we have received have come from our members and friends. An active membership is our most valuable asset. Your friends will welcome the idea of becoming interested in the affairs of the organization by joining as contributing members.

The yearly dues are $2.50.

Come to our Regional Meetings and to the Annua Convention. You and your friends are cordially invited t most enjoyable meetings.

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Secretary's Script . . .

Participate in Your Profession's Decisions

The meetings and Annual Convention of the MPhA are occasions to learn and exchange ideas. They are also important as the time to participate in making policy decisions for pharmacy in Maryland.

The Annual meeting will cover the gamut of the critical issues affecting pharmacy. Perhaps few are more critical than "third-party" payment plans. We are more than aware of the impact of one governmental "third-party" payment plan, namely, "Medicaid."

Last year a union plan went into effect and this year Blue Cross began implementation of its drug program. This is just the beginning of what in a few short years will constitute perhaps 75% of the total prescription volume in community pharmacies.

We are therefore devoting one morning to a panel discussion featuring representatives of Blue Cross, Pharmaceutical Card System (PCS), union plans and "Paid Prescriptions."

The issue of continuing education will be discussed by Dean Warren E. Weaver of the Medical College of Virginia and President of the American Association of Colleges of Pharmacy. Shall continuing education be mandatory or left to the individual? Will pharmacists or the public decide for all professions?

Drug abuse has become pervasive in our society. Federal state and local laws are confusing. Now the Federal Bureau of Narcotics and Dangerous Drugs is proposing an Omnibus Drug Bill to consolidate and update all federal laws in this area. Two top federal officials, John Finlator, Associate Director and Michael Sonnenreich, Associate Legal Counsel to BNDD will discuss the new proposal. George B. Griffenhagen, Editor of the APhA Journal and Chairman of the National Coordinating Council on Drug Abuse Education and Information will discuss "The Role of the Pharmacist in Drug Abuse Education."

Of course, important business sessions will also be conducted with nominations and elections scheduled for Thursday.

This is but a part of the program. In addition, TAMPA and LAMPA will hold their meetings and feature entertainment for everyone.

So participate in your profession's decisions—attend your Annual Meeting.

NATHAN I. GRUZ,
Executive Secretary

87th Annual Convention
Maryland Pharmaceutical Association
in conjunction with
The Ladies and Travelers Auxiliaries
July 13-17, 1969
Tamiment-In-The-Poconos

Maryland Board of Pharmacy News . . .

Pharmacy Changes

The following are the pharmacy changes for the month of February:

New Pharmacies

Dart Drug Corporation, Laurel, Herbert H. Haft, President, 123 Bowie Road, Laurel, Maryland.

Read Drug and Chemical Company, Arthur K. Solomon, President, Yorktowne Shopping Center, York and Cranbrook Roads, Cockeysville, 21030.

No Longer Operating As Pharmacies

Adams Drug Company, Miriam R. Highkin, President, 1401 Edmondson Avenue, Baltimore, Md. 21223.

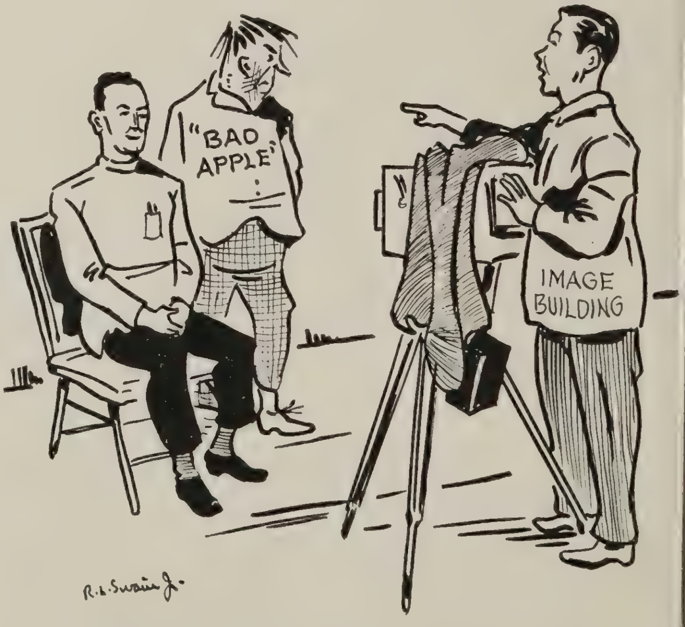
Allen's Professional Pharmacy, Dorothy Washington, President, 255 N. Payson Street, Baltimore, Maryland 21223.

Medical Arts Pharmacy, Samuel Wertheimer, President, 29 S. Center St., Cumberland, Maryland 21502.

Changes of Ownership, Etc.

District Heights Medical Center Pharmacy, Richard W. Williamson, 6400 Marlboro Pike, District Heights, Md. 20028 (Formerly owned by K. L. Minchin and Walter B. Sherr).

Edwards Pharmacy, J. D. & Mary Ann Edwards, 102 Commerce Street, Centreville, Maryland 21617 (Change of name from individual ownership to corporation—Formerly known as Thompson's Pharmacy).



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But this is just the beginning. There is more to come. And if you have any requests or ideas, please speak up. At Roche, we solicit and value your opinions. They help us to help you.

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Early Pharmacy in the Baltimore Campus Area (University of Maryland)

by

B. F. ALLEN

In 1907, one of the speakers at a meeting of the University of Maryland Alumni urged the removal of the professional schools, together with the hospital to some new location in the northwestern section of the city, where there was a more healthy, physical and moral environment. The speaker (a University of Maryland professor of physiology) also stated this should be considered before any further funds are spent in the construction of new buildings at Greene and Lombard Streets.

In 1968, the old corner has changed and the cobblestones are gone. Gone, too, are the old neighbors and the drugstores, as well as two important street car lines that crossed immediately through the heart of the University.

The sight and sound of bulldozers, cranes and construction crews have become a part of everyday life as the greatest growth in Baltimore Campus history seems to be under way.

In a previous article (This Journal, June 1968), points of pharmaceutical interest were presented around the year 1926 and before, within an area bounded by Fayette and Paca Streets, the Washington Boulevard and Fremont Avenue.

It is extremely interesting to note that during the period of about 1926, Baltimore-made drugs, pharmaceuticals, labels and boxes of all kinds, as well as equipment, fixtures and other sundries for the drug trade, were being shipped to all parts of the globe, and some of the largest manufacturers of these goods were located right here in Baltimore.

Historically, the original site of the University has been encroached upon by factories; the atmosphere has been thick with smoke and the noise intolerable. However, even with this general turmoil, dust, restlessness and at times confusion, there has been real progress. Just a few blocks outside of the expanding Baltimore campus, many interests pharmaceutical in nature have been in existence and are depicted in the following map.

LEGEND:

(1) Emerson Drug Co. (the Bromo-Seltzer Tower Building built in 1911 and topped by a huge blue bottle was then the tallest building in Baltimore, 357 feet high).

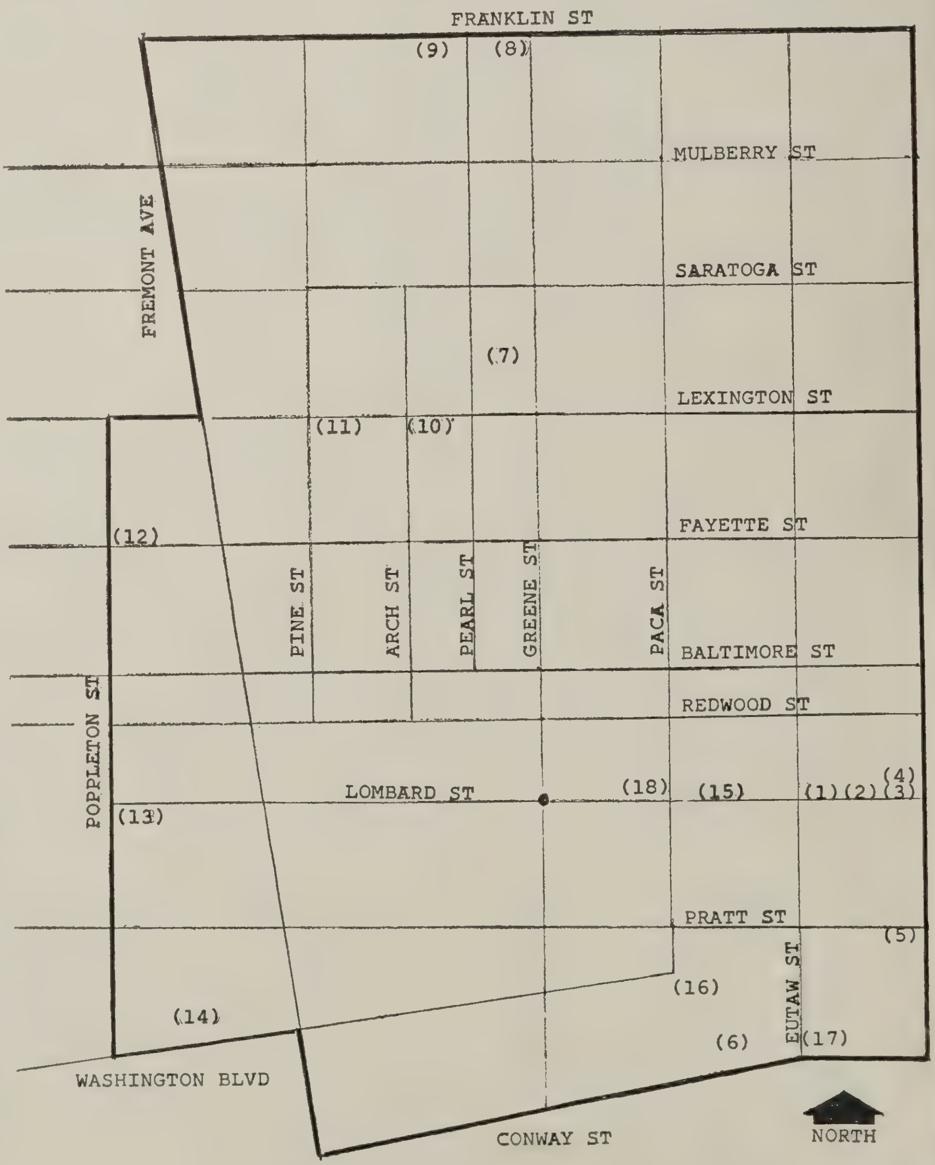
(2) Gilbert Brothers and Co., manufactured Yager Liniment early in the century.

(3) Henry B. Gilpin Co. (302 W. Lombard Street), at one time housed the office of the Maryland Pharmaceutical Association.

(4) Quandt's drugstore (northwest corner of Howard and Lombard Streets).

(5) Sharp and Dohme, manufacturers of pharmaceuticals and chemicals Howard and Pratt Streets), several buildings remain today and are occupied by the John C. Stalfort and Sons Co., Inc.

(Continued on page 28)



A continuing Article, Part I, was published in the **Maryland Pharmacist**, August 1966 and Part II in the June 1968 issue. The author is Associate Professor of Pharmacy, University of Maryland.

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. . THE SYMBOL OF SERVICE TO PHARMACY

Oral Inhalation Aerosols

by

Kenneth S. Sumida*

INTRODUCTION

Inhalation therapy has been defined as "the administration via the respiratory system of medicinal agents which are in the form of fine solid particles or a liquid mist"(1). Although this method of administration is not new, inhalation therapy provides an area of untapped potential for the administration of medicinal agents.

Among the many advantages of inhalation therapy are: 1) the rapidity of onset of action, which in many cases approaches that of intravenous therapy; 2) the elimination of the need for sterile technique, materials and equipment for parenteral administration, as well as the trauma and discomfort accompanying injection; and 3) the elimination of the problems of decomposition or loss of drug in the gastro-intestinal tract.

A number of devices are available for administering medicinals by inhalation. Among the more common ones are atomizers, nebulizers, insufflators, and vaporizers. All of these devices have the disadvantage of need for cleaning, possible contamination of the inhalant, and lack of strict control of dosage. The vaporizer has the additional disadvantage of requiring a volatile substance which is vaporized by the steam generated.

Another device which is widely used in hospitals and other institutions for inhalation therapy is the Intermittant Positive Pressure Breathing apparatus, commonly referred to as the I.P.P.B. apparatus. The I.P.P.B. apparatus is a type of respirator used where distressed breathing due to pulmonary obstruction requires mechanical help. It can be made to operate automatically and is activated by the patient's own inspiration efforts. The I.P.P.B. respirators may also be equipped with a nebulizer for the administration of mucolytics, bronchodilators and wetting agents as nebulized particles in the air stream.

The aerosol package overcomes many of the disadvantages of the previously described devices by affording a sealed unit, thereby eliminating the danger of contamination, much better control of dosage and a convenient easy-to-use, easy-to-carry container.

ANATOMY AND PHYSIOLOGY OF THE RESPIRATORY SYSTEM

Before considering the physical properties of aerosols it may be worthwhile to briefly review the anatomy and physiology of the respiratory system. The anatomical arrangement of the respiratory system has been described (2) by separating it into three main parts: 1) the nasopharyngeal structure: 2) the system of branching ducts, beginning with the trachea and ending with the terminal bronchioles; and 3) the pulmonary structure.

The nasopharyngeal structure consists of the oral and nasal cavities through which the inspired air enters the respiratory system. The air then enters the pharynx, the larynx and into the trachea. From the trachea the air passages begin to branch and divide into two main bronchi. Each of the main bronchi enter their respective lungs, the right bronchi branching into three lobar branches and the left into two lobar branches. The lobar branches in turn divide and subdivide into smaller branches and eventually into terminal bronchioles. Each terminal bronchiole then divides into two respiratory bronchioles, so-called because of their transition to alveolar type of epithelium. The respiratory bronchioles subdivide twice with each dividing into two alveolar ducts which then give rise to the ultimate respiratory structure, the alveolar sac, of which there may be from three to five opening into each alveolar duct.

DEPOSITION AND RETENTION OF INHALED PARTICLES

The effectiveness of administering medicinals via inhalation will be dependent on the deposition and retention of the inhaled particles at the desired sites within the respiratory system. Deposition of inhaled particles in the respiratory tract is thought to occur by three mechanisms(3): 1) inertial impaction; 2) sedimentation; and 3) Brownian motion. Inertial impaction is thought to be important in the nasal airways and upper respiratory tract where the air velocity is quite high. The larger particles are likely to be separated by this mechanism. Sedimentation is important in the deposition of larger particles in the deeper portion of the lungs where the air velocity has been reduced. Brownian motion is important in particular deposition in the alveolar sacs where air velocity is quite low.

Hatch and Gross (2) have attempted to summarize the deposition characteristics of the respiratory system as follows:

1) Percentage deposition increases from a minimum of about 25% at approximately 0.5 micron and approaches 100% for particles greater than 5 microns.

2) Percentage deposition also increases as particle size decreases below 0.5 microns. It has been suggested that alveolor deposition of submicronic particles approaches 100% of the fraction that reaches this region.

3) Percentage deposition varies with breathing frequency.

---

* Mr. Sumida is presently a graduate student working in the aerosol research laboratory at the University of Maryland, School of Pharmacy, under the direction of Dr. Ralph F. Shangraw. He is a graduate of the Albany College of Pharmacy in Albany, New York, and has been engaged in aerosol product development for both Sterling-Winthrop Research Institute in Rensselaer, New York, and The Norwich Pharmacal Company in Norwich, New York, prior to his graduate studies.

It should become evident that the particle size of inhaled medicaments is of great importance in determining the type of drug action that will result. Local or systemic activity or a combination of both can be produced with a proper particle size distribution. In a discussion of dexamethasone sodium phosphate inhalation aerosols by Grim, *et al.*, (4) suspensions of this drug conforming to a size specification of 95% of the mass of the particles below 5 microns in diameter, were found to be clinically effective in the treatment of various asthmatic states.

Although particle size of the inhaled material is of paramount importance, other parameters can affect the deposition and retention of this material. A diseased state of the lungs, such as bronchoconstriction can cause variable deposition. The inhalation of hygroscopic materials may result in growth of the particles as they pass through the respiratory system. As mentioned before, breathing frequency and also tidal volume will affect deposition and retention.

AEROSOL INHALATION PRODUCTS

The first self-pressurized inhalation aerosol to be made available was Medihaler-Epi introduced by Riker Laboratories in 1955. This product contains epinephrine bitartrate dispersed in propellents with the aid of a dispersing agent. Following the introduction of Medihaler-Epi a number of similar products were made available for relieving the symptoms of asthma and bronchitis. Table 1 shows the various products now available in the self-pressurized aerosol package.

It can be seen from the table that two types of formulations are available; either solutions or suspensions. The suspensions are dispersions of finely divided drug suspended in the propellent mixture with the aid of a dispersing agent. The dispersing agents commonly used are sorbitan trioleate, oleyl alcohol, or a small percentage of ethyl alcohol. The solution type of inhalation aerosol are solutions of the drug in mixtures of ethyl alcohol and propellents. Flavors and antioxidants are generally found in the solution type of product. The common antioxidants utilized are ascorbic acid and ascorbyl palmitate, and are necessary since both isoproterenol and epinephrine will undergo oxidation in solution.

The propellents used in inhalation aerosols are fluoro- and chloro-substituted methanes and ethanes. The three propellents encountered most often are dichlorodifluoromethane (Propellent 12), trichlorofluoromethane (Propellent 11) and dichlorotetrafluoroethane (Propellent 114). These propellents have vapor pressures at 70° F. of 70.2, 13.4, and 12.9 p.s.i.g., respectively. By varying the ratio of the propellents used the formulator is able to obtain formulations with a wide range of vapor pressures and discharge characteristics.

The effectiveness of bronchodilators administered via oral inhalation by means of self-pressurized devices has been well documented. Cohen and Hale (5) have reported that relief of bronchoconstriction afforded by isoproterenol and isoproterenol-phenylephrine combinations delivered by the aerosol package was equal to or greater than that obtained by the use of I.P.P.B. apparatus and at decreased bronchodilator dosages. In a study showing the effectiveness of Medihaler-Iso, Kallos and Kallos-Defner (6), found that prompt relief of the objective and subjective symptoms of acute asthma attacks and beneficial effects in cases of chronic bronchial asthma were obtained.

Fisch and Grater (7), have reported that dexamethasone phosphate administered by inhalation as a suspension of the steroid in inert propellents (Decadron Respihaler$^{(R)}$) was effective in the control of asthma. One of the advantages of this type of therapy, as pointed out by these authors, was the decrease in total dose of steroid required as compared to oral administration. In response to the lower dose ingested there was a diminishing of side effects. It was

TABLE 1. ORAL INHALATION AEROSOLS

Product and Manufacturer	*Type of Formulation*	*Active Ingredients*	*Inert Ingredients*
Medihaler-Iso (Riker)	Suspension	Isoproterenol SO_4	Propellents and sorbitan trioleate
Medihaler-Epi (Riker)	Suspension	Epinephrine Bitartrate	Propellents and sorbitan trioleate
Duo-Medihaler (Riker)	Suspension	Isoproterenol HCl Phenylephrine Bitartrate	Propellents, cetylpyridinium Cl and sorbitan trioleate
Medihaler-Ergotamine (Riker)	Suspension	Ergotamine Tartrate	Propellents and sorbitan trioleate
Isuprel Mistometer (Winthrop)	Solution	Isoproterenol HCl	Propellents, flavor, alcohol, ascorbic acid
Bronkometer (Breon)	Solution	Isoetharine Methanesulfonate Phenylephrine HCl Thenyldiamine HCl	Propellents, menthol, saccharin, alcohol, ascorbic acid
Norisodrine Aerotrol (Abbott)	Solution	Isoproterenol HCl	Propellents, flavor, sodium saccharin, ascorbyl palmitate and alcohol
Respihaler Decadron (MSD)	Suspension	Dexamethasone-21-phosphate	Propellents and alcohol 2%
Respihaler Prodecadron (MSD)	Suspension	Dexamethasone-21-phosphate Isoproterenol SO_4	Propellents, alcohol and anhydrous sodium sulfate
Primatene Mist (Whitehall)	Solution	Epinephrine	Propellents, alcohol and ascorbic acid
Asthma-Nefrin (Thayer)	Suspension	Racemic Epinephrine HCl	Propellents and oleyl alcohol
Vapo-N-Iso (U.S. Vitamin)	Suspension	Isoproterenol SO_4	Propellents and oleyl alcohol
Vaponefrin Metermatic (USV)	Suspension	Racemic Epinephrine HCl	Propellents and oleyl alcohol
Asthma-Meter Mist (Rexall)	Suspension	Epinephrine	Propellents
Bronkaid Mist (Drew)	Solution	Epinephrine and ascorbic acid	Propellents, alcohol and ascorbic acid

also noted that many chronic asthma patients who were steroid-dependent could be transferred completely to inhalation dexamethasone at a much smaller total steroid dose than when treated orally.

The one product shown in the above table not used for the relief of asthma is Medihaler-Ergotamine. Its usefulness in the relief of migraine headaches also has been shown by a number of investigators. Finch (8) has reported that results obtained from inhalation of ergotamine tartrate were significantly better than results obtained with oral therapy and virtually as good as those obtained by injection.

NEW DEVELOPMENTS IN INHALATION AEROSOLS

The administration of a number of therapeutically active agents by inhalation, other than those cited above, has been investigated. These include (9) antibiotics, antitubercular drugs, antispasmodics, mucolytics, surface-active agents and vitamins.

In a recent publication, Blaug, Fischer and Miller (10) reported their efforts in developing bronchographic and laryngographic techniques by the inhalation of propylidone as the radiopaque contrast agent. The propylidone was formulated as a dispersion in fluorinated hydrocarbon propellents with the aid of a dispersing agent.

The propylidone formulations were evaluated *in vivo* in anesthetized dogs by spraying short bursts from the aerosol into an intratracheal tube. X-rays were taken before and after administration of the contrast agent and compared. The results of these investigations showed that inhalation of propylidone provided good outlining of the larynx and primary bronchi. It did not, however, completely outline the bronchial tree. It should be pointed out that under anesthesia, the dogs have a reduced respiratory rate and do not breathe deeply. It would be expected that under conditions of normal respiration and more certainly under forced inspiration, that the penetration of the contrast agent would be increased and would yield better bronchial outline.

It appears reasonable that with additional investigation that contrast agents administered via inhalation could at least supplement today's radiologic techniques.

Another interesting application of inhalation therapy is the administration of vaccines by this route. In a study conducted by Waldman, Small and Mann (11), dead flu virus sprayed directly into the respiratory system was found to be superior to standard flu shots in protecting against influenza. These findings were based on results of clinical trials on over 2000 Florida prisoners during an Asian flu epidemic which hit the Florida State Prison at Raiford, Florida.

These results were as follows:

1) 8 of 320 men receiving the spray vaccine became ill with flu (2.5%). Of these 8 men, 5 were well by the third day.

2) Of 260 men given standard flu shots, 9% got the flu and were sick for approximately six days.

3) In a third group of 1400 men who received no innoculation. the illness rate was 12%.

The authors based their conclusion of superiority of the spray vaccine on the ease and comfort of administration (free of sore-arm and fever commonly associated with the shot), lowered incidence of vaccine side effects, greater protection during an influenza epidemic, and shorter duration of illness for those few who did become ill. This study furnishes hope for inhalation as an immunization technique, providing a more convenient method than is currently available.

PROPELLENT TOXICITY

The development of aerosol inhalation products is beset with numerous problems, among which are: 1) determining the correct particle size of the medicament and the attainment of the proper particle size range; 2) economically producing submicronic and micronized particles; 3) determining the pressures required for optimum penetration of inhaled particles; 4) strict control over dosage; 5) the effects of valve components on the stability of the ingredients in the formulation; and 6) the effects of the inhaled medicament and other ingredients such as the propellents employed, any additives, and possible foreign contamination from the container or gasket on the lung.

Recently a great deal of concern has been voiced over the inhalation of propellents from products meant to serve as glass chillers. The abuse of this product has resulted in the death of a number of individuals inhaling its contents. It has been postulated that death resulted from asphyxiation due to the freezing of the upper respiratory structures by the propellent. Death may also be due to simple asphyxiation due to replacement of air in the lungs by the much heavier vapors of the propellent. Although most deaths across the country have been as a result of the misuse of glass chillers, other aerosol products sprayed first into plastic bags and then inhaled have resulted in death. A recent death in Baltimore was the result of this type of misuse of the aerosol antiseptic product Bactine$^{(R)}$. As far as it is known all deaths from aerosol products have resulted from their premeditated misuse. However, such deaths may serve to deter the development of inhalation pharmaceutical aerosols as long as the exact nature of the toxicity is not established.

Most of the toxicity work done on compounds used as propellents have indicated a low index of toxicity. The Underwriters' Laboratories have classified inhalation toxicity of gases and vapors into various groups. The definition of each group and the group to which the compounds frequently used as propellents are placed are found in Table 2 (12). Also included are other gases and vapors for a comparison of inhalation toxicity.

Although it would appear that the commonly used propellents are relatively innocuous, Quevauviller (13) cautions that before pronouncing these compounds totally innocuous, that it would be wise for thorough investigations to be conducted to confirm this. In experiments conducted by this investigator, the results showed that propellents 11, 12, and 114 were poorly tolerated by the pulmonary parenchema. These tests were performed on mice which were exposed to an atmosphere of 10,000 ppm by volume of the propellents continuously for 24 hours.

In his paper, Quevauviller also summarized the results of F. Caujolle (14) on the comparative toxicity of some of the propellent compounds. Limiting ourselves to a discussion of propellents 11, 12 and 114, the following information was given.

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Propellent 11—The immediate toxicity is apparent at high concentrations and is far from insignificant at low concentrations; at an atmospheric concentration of 15 vol.% mice succomb within a few minutes, and in an atmosphere with 25 vol.% the mortality level for guinea pigs in 30 minutes is 50%. At concentrations of 3 to 6% after 2 hours of exposure, guinea pigs undergo severe but non-lethal intoxication.

Propellent 12—This derivative is stable and only slightly toxic. A 5% concentration in inspired air produces no immediate symptoms; at high concentrations, of the order of 20 vol.% in inspired air, prolonged and repeated exposures do not lead to any lasting disturbances in guinea pigs, dogs or monkeys; — mice may show signs of agitation.

TABLE 2
UNDERWRITERS' LABORATORIES CLASSIFICATION

Group	*Definition*	*Example*
1	0.5 to 1 vol.%—serious injury in 5 minutes	Sulfur dioxide
2	0.5 to 1 vol.%—serious injury in 30 minutes	Ammonia Methyl Br
3	2 to 2.5 vol.%—serious injury in 1 hour	Bromochloromethane CCl_4 Chloroform Methyl formate
4	2 to 2.5 vol.%—serious injury in 2 hours	Dichloroethylene Methyl Cl Ethyl Br
4-5	Less toxic than 4 and more toxic than 5	Methylene Cl Ethyl Cl Freon 112* Freon 113 Freon 21
5a	Much less toxic than 4 but more toxic than 6	Freon 11 Freon 22 Freon 114B2 Freon 502 CO_2
5b	Data indicating classing as 5a or 6	Ethane Propane Butane
6	20 vol.%—no injury in 2 hours	Freon 13B1 Freon 12 Freon 114 Freon 115 Freon 13* Freon 14* Freon 23* Freon 116* Freon C318*

*Not tested by the Underwriters' Laboratories but estimated to belong in group indicated.

Propellent 114—The tolerance was studied via inhalation, by experiments on acute and subacute intoxication (17 days) at concentrations of 0.1 to 3% in air; the 3% concentration in air can rapidly cause death in rats, autopsy revealing hemorrhagic foci in the lungs. The maximum tolerable concentration for rats as determined by inhalation is 0.1%.

Caujolle cautioned that "it is never possible to prejudge the potential risks entailed by chronic administration of very weak doses of a substance which is apparently harmless when given experimentally over a short time in high concentration."

It appears that all investigators are not in strict agreement over the inhalation toxicity profile of propellents. It should be noted, however, that the tests conducted by these investigators differed in most cases and that any inhalation toxicity noted was caused by the inhalation of concentrations much higher than would normally be encountered.

It is extremely important that all pharmacists understand the nature and effects of aerosol products, particularly those used by inhalation. The pharmacist can serve an important role in making sure that all patients use pharmaceutical aerosols correctly and to caution all persons about the danger of their intentional misuse.

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"DOC" and Me

By M.M.

The following manuscript was submitted in fulfillment of an assignment in Pharmacy 35: Professional Communications—at the University of Maryland School of Pharmacy. The student was asked to analyze a pharmacist with whom he had had personal contact, pointing out what he considered to be good and bad qualities. I am sure that many readers of **The Maryland Pharmacist** will enjoy this humorous and warm study of pharmacy and a pharmacist in a small Maryland community.

Ralph F. Shangraw, Ph.D., Associate Professor
Department of Pharmacy, University of Maryland, School of Pharmacy

How can I describe Doc? How can I explain what there is about him that commands so much respect? It's impossible to put my finger on any one thing. No, I believe the most important things about him are intangible. Maybe it would be best to start at the beginning with Doc and his relationship with the town itself.

Doc serves a rural farming community of approximately fifteen hundred people. Not so long ago all of the people in town were natives but lately there are more and more young families moving into the area. Most of the people work in Baltimore or Washington and they travel back and forth daily, looking forward to getting out of the city at five o'clock and home to the country. The average income is about thirty-five hundred dollars a year, give or take a thousand or so.

The Only Drug Store In Town

Doc owns the only drug store in town. The nearest competition is seven miles to the south, or seven miles to the east, or fifteen miles to the north, or thirteen miles to the west. The closest large scale discounter is twenty-five miles away. The grocery stores in town carry small lines of patent medicines, but these businesses are small and their owners respect the other businesses in town. When people want groceries, they go to the grocery store; when they need aspirin, they go to the drug store. They don't go to the drug store for fish, liquor, or used cars!

There are two doctors in town: one, an old timer of sixty-nine years of age; the other, a go-getter of forty-eight who built his own clinic two years ago. The drug store is centrally located with the other stores on Main Street. There are two windows in the front; one displaying pill tiles, mortars and pestles, show globes, —an art of pharmacy window usually; the other a seasonal display, vitamins in winter and sunburn supplies in summer.

The Prescription Department

The prescription department is straight across the back of the store. Customers have no problem finding their way there. There is a ten stool soda fountain behind which is another display instead of the typical mirror plastered with sandwich signs. This display is a center of attraction among townspeople. It is changed with holidays or events of local interest. For example, the bells which were hung to ring in the New Year were replaced by a display highlighting the local high school basketball team and its efforts in capturing the county championship.

The store is open from 8:30 a.m. to 9:30 p.m. Many nights I have waited for the conclusion of lively discussions on politics, school, or horses, which often delay closing until 10:30 or 11:00 p.m. Actually, as long as Doc is in the store, no one is ever turned away.

The only outside help hired in the store are two women; one works the eight-thirty to four shift daily, the other from six to nine-thirty. This is a family run store. Doc has six children and is a firm believer in starting them out early to learn by doing. Applicants for after school jobs as soda jerks are brought around behind the soda fountain. If they can reach across the counter, the job is half theirs. However, with six soda jerks of his own, five girls and a boy, ranging from thirteen to twenty, there aren't too many job openings.

The oldest started working regular hours at the ripe old age of twelve, one hour after school and all day Saturdays. She began the way they all do, behind the soda fountain. Advancing to the prescription counter, she became fascinated and soon decided to make a carreer of pharmacy. Doc's son is now in the Navy. He took a crack at working in the store and hated every minute of it. I suppose that Doc would have liked his son to take over some day, but he didn't force the issue when he realized that the interest wasn't there. The other girls are in the soda fountain stage in varying degrees; the youngest at a quarter an hour and the oldest at seventy-five cents.

Seldom are orders necessary. When the cellar needs cleaning, the oldest girl does it. She makes sure that there are enough of Dr. Jones' pain capsules made up and if not, she packs 300 at a spin. She keeps the shelves stocked, dusts and rearranges merchandise constantly. She also makes syrups for the soda fountain, decorates the store and trims the windows. She knows how to slow down an impatient customer when Doc's stretched out flat on his back in the office. She opens up, works on five minutes notice, counts up, closes up at night. Doc expects all this.

Work Expectations

He expects his clerks to work when he wants them to work and not when **they** want to work. The kids must work their schedule the same as anyone else and they stand in line Saturday night waiting for their pay just like everyone else. They are learning the value of money the way Doc did, the hard way.

The money is theirs—soon they will become self-supporting, buying all their own clothes, and whatever else they might want. One of his girls once told Doc that she'd worked her fingers to the bone for him and what had she gotten from it? Bony fingers! Of course, Doc and she both realize there's something else. It sticks out all over in the form of pride. She knows she's worked hard because she wanted to and not because she had to.

Hard Work

Doc's worked hard all his life and is used to it. Even now he is working a six day, seventy-five hour week himself with no relief. Not that he isn't looking for a relief man but there just doesn't seem to be one around. Uncle Sam took such a liking to his last relief man that he sent him to Germany for a couple of years! Sometimes Doc gets discouraged and talks of retiring and selling out, but in three years there will be a new pharmacist readily available right in the family, he thinks.

I feel all of this is important in explaining Doc. He treats his clerks as people. They know he doesn't like them slacking off and he wants them to find something to do without having to be told. When working on the soda fountain the girls know they're supposed to whistle, so he knows they aren't eating up all the profits.

Everyone works hard for Doc, realizing at the time that they won't be verbally thanked for it, but also knowing that he appreciates it and notices everything that's been done. His eyes don't miss a thing and he can hear every word that's being said in the entire store.

Doc Commands Respect

Doc doesn't wear a white coat—he doesn't have to. His mere presence commands respect. I know this sounds melodramatic, but I swear that it's true. He is the best public relations man I have ever seen. He can talk to anyone about any subject intelligently. If he doesn't know what he's talking about, he certainly sounds like he does. Doc would have made good in any profession. Doc says that those pharmacists that are always complaining would be complaining no matter what job they had.

Doc is a man of varied interests. Two years ago he picked up the antique bug. There are now two shelves of antiques on display even though they don't encourage any sales. Last summer he became an avid fisherman. Now there is a six-foot marlin mounted behind the fountain. His main side interest, though, is horses. After a long day at the store, he gets a kick out of spending ten to fifteen minutes out at the farm talking horses. (No, he's not talking **TO** horses yet!) He has also become interested in real estate and has had a good time remodeling a house which he now rents.

Doc is very well read. In his office can be found the latest volumes of the A.Ph.A. Journal, American Druggist and The Maryland Pharmacist, as well as a variety of other non-professional publications, such as Barrons Financial Weekly, Horseman's Journal and Time. He is a member of the A.Ph.A. and the Maryland Pharmaceutical Association. He has served on several committees, but when it comes to active participation in State associations, he procrastinates like so many others.

Community Influence

Doc is very prominent and influential in the community. He has been a member of the Lions Club, Kiwanis Club, and helped with Boy Scouts. He is past president of the County Association for Retarded Children and played a main part in its organization just a few years ago and helps out in health campaigns such as the polio immunization program. Doc doesn't do these things to create an impression; it is quite obvious from the way he throws himself into such work that he is enjoying himself.

Doc's relationship with the two doctors in town is very good. The doctor downtown drops in the store several times a day, the other several times a month. Both get equal phone treatment. Doc is always congenial and always takes time to pass the time of day. They respect Doc and don't hesitate to ask for drug information. Doc, in turn, doesn't hesitate to phone them any time he is unsure of something although he is considerate of their time. I believe that Doc's professional status in the community is equal to that of his medical associates.

Public Relations

In relations with the public, he always handles problems professionally. It amazes me how he is never stumped as to what to suggest for minor aches and pains of the public. There is no hemming and hawing around with him. If they need a doctor he tells them so in no uncertain terms. In a small town such as this everyone knows everyone else. Doc does a lot of special ordering for these people. They know that they are getting good personalized service.

So far, Doc seems to be the perfect individual. And yet, no one is perfect. Doc has his shortcomings. When he's in a bad mood, it's really bad. He can be very short at times. I have never seen him tell anybody directly to "Go to Hell." Indirectly, yes, but he is always very tactful. When someone loudly persists in fighting the rising cost of prescriptions—the "cheaper to die line," Doc very eloquently straightens them out.

Behind the counter, I have seen Doc do the worst imaginable thing professionally—licking labels. I had seen it done for years and it never even occurred to me that it wasn't professional. Although it may be terrible, the prescription counter isn't open to view and no one can see him do it. This is pretty slim justification, I know. I'll never forget that first pharmacy lab when we all sat there in the model pharmacy petrified. I know I've never had a more terrible sinking feeling right in the pit of my stomach than when the "sin" of licking labels was announced. Everyone else sat there unmoved visibly, and I wondered if all my years experience had been obtained in an illegal drug store. I remember telling the Dean, passing him in the hall that first week, that I had to go home and straighten out Doc's professional practices. The first weekend home from school, a sponge jar was initiated. It's still there but I notice it's dry except on weekends.

I congratulated Doc on having a good prescription balance. I had been told to expect antiques which couldn't possibly be accurate. Doc's balance might look old but it has had good care and is as good as new. In a very real sense Doc is going to school with me. He is always interested in what we're doing in comparison with his course at Maryland.

A Dedicated Professional

By all this I don't mean to say that Doc is not professional. Doc is the epitome of a dedicated professional. Everything that he does is done with technique and he's often told me that good technique is one of the most important pre-requisites of a good pharmacist.

It wouldn't be possible to list all of the things that make me proud of Doc as a human being and a pharmacist. I've seen Doc send a boy out on the street to help Mr. Smith carry his groceries to the car. Mr. Smith is eighty-four years old and has a bad heart . . .

I've seen Doc rush out of the store and patch up a horse that had gotten all tangled up in barbed wire . . .

I've seen Doc rush gawking customers out of the store and lock the door to help an epileptic who had just had an attack . . .

I've seen Doc bandage up a finger that had been smashed in a car door when the patient insisted it was all right and didn't need anything done to it . . .

I've seen Doc come out and give Dorothy a hand on the soda fountain when she got rushed . . .

I've seen Doc sleeping on a cot in the office after hanging a notice to salesmen saying that he wasn't in . . .

I've seen Doc take the suppository mold out of the ice cream cabinet; I always did wonder what that thing was —now I know!

I really can't begin to give a complete picture of Doc's character even though I've spent twelve years working for him. I can't possibly tell all the circumstances that make me hold him in such high esteem, that have made me always want to be just like him.

Doc is definitely a valuable member of the profession of pharmacy and I hope someday to show him how much I've appreciated being able to learn from working with him by being just as valuable and doing my very best for pharmacy.

By the way, I must confess that this report may not be as objective as it should be. I really tried, but you see, DOC is my FATHER.

EARLY PHARMACY

(Continued from page 14)

(6) Standard Pharmaceutical Corp. (417 W. Conway Street).

(7) Huthwelker's drugstore (218 N. Greene Street).

(8) Futterman's drugstore (Greene and Franklin Streets).

(9) Franklin drugstore (Pearl and Franklin Streets).

(10) Solomon's drugstore (631 W. Lexington Street).

(11) Wolfe's drugstore (Pine and Lexington Streets) may have been established in 1853.

(12) Branning's drugstore (891 W. Fayette Street).

(13) Harris' drugstore (Poppleton and Lombard Streets), Samuel Y. Harris was president of the Maryland Pharmaceutical Association, 1925-26. The present owner is Milton A. Friedman, President of the M.P.A., 1967-68.

(14) Gakenheimer's drugstore (752 Washington Boulevard).

(15) Former location of the Germania Maennerchor Hall (410 W. Lombard Street), many University social functions were held here including the Centennial preliminary mass meeting of the alumni (January 1907). The representative from the pharmaceutical department on the program was Charles Caspari, Jr., first Dean of the School of Pharmacy.

(16) Unidentified drugstore (southeast corner of Paca and Pratt Streets).

(17) Burrough Brothers, pioneers in pharmaceutical manufacturing were located in 1893 at 304 S. Eutaw Street.

(18) In 1860, 88 S. Paca Street was the residence of Alpheus P. Sharp. Merck, Sharp and Dohme can trace its origin to the 1845 opening of his pharmacy in Baltimore. (The residence address may not be in the correct location on the map since the street numbering system in Baltimore was revised in 1887).

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Gilpin Extends Health Care Products

Marketing

The Henry B. Gilpin Company has undertaken a comprehensive program to extend Gilpin's health care and hospital-surgical products marketing in the announcement of the pooling of interest of the McKenna Surgical Supply, Inc. and the Henry B. Gilpin Company. The announcement was made jointly by Mr. Jack Kolman, Sr. President of McKenna Surgical Supply, Inc., and Mr. James E. Allen, Chairman of the Board and President of the Henry B. Gilpin Company.

Marketing Extended

Mr. Allen stated that this acquisition is the first key move in a comprehensive program to extend Gilpin's health care and hospital-surgical products marketing. Gilpin will continue to operate within its own drug industry, autonomous from the hospital-surgical field. The computer facilities, marketing techniques, professional inventory management, and administrative personnel talent of Gilpin will be made available to McKenna, as added forces for expansion and growth in marketing products and services to the public, hospitals, and physicians.

Burton Named Executive

Mr. John C. Burton has been elected Executive Vice President of McKenna Surgical Supply, Inc., and head of the new Consumer Merchandising Division of the Henry B. Gilpin Company, and he will assume full responsibility for the management of the total operation.

Prior to joining Gilpin, Mr. Burton was associated with the Ethicon Division of Johnson and Johnson, rising from Sales Representative through Regional Sales Manager to be Assistant to the Vice President of Sales. He was also Marketing Manager of the Medical Division of the Howmet Corporation, a leading producer of surgical and dental appliances.

Left to right: William H. Whittlesey, James E. Allen, John M. (Jack) Kloman, Sr., and John C. Burton.

Obituaries . . .

CHARLES L. YOUNG

Charles L. Young, a long time member of the Maryland Pharmaceutical Association and the Baltimore Metropolitan Pharmaceutical Association died on December 8, 1968. He was the owner of the McAlpine Pharmacy, located on the Baltimore National Pike in Howard County.

Born in Baltimore, Mr. Young was a 1931 graduate of the University of Maryland School of Pharmacy.

Besides his wife, the former Ruth Beach, his survivors include a son, Charles F. Young, of Catonsville, and two grand children.

WILLIAM J. SULLIVAN

William J. Sullivan, president of the Washington County Pharmaceutical Association died on December 17, 1968. He had resided in Williamsport for the past five and one-half years and operated the Village Pharmacies.

HENRY ECKHARDT

Henry Eckhardt, 71, who owned the College Pharmacy, Frederick and Marydell Roads for 40 years from 1926 to his retirement two years ago, died December 27, 1968. He is survived by his widow, Margaret M., a son Henry Jr., and daughter, Mrs. Joseph Burton, and six grandchildren.

Mr. Eckhardt was a graduate of the University of Maryland School of Pharmacy, 1920, and employed by Read's before opening his own store. He was a lifetime member of MPhA.

Henry Eckhardt, Jr. is the District Manager of the Coca-Cola Company and a member of TAMPA.

J. LOUIS GUNDLING

J. Louis Gundling, 69, pharmacist and retired Vice President of Peoples Service Drug Stores, Inc. died January 10, 1969. A native Washingtonian, Mr. Gundling was a 50 year veteran of the drug store chain. His association with Peoples carried him from clerk, assistant warehouse manager and pharmacist to buyer of drugs and pharmaceuticals. Elected to the Board of Directors in 1950, he was promoted to Vice President in Charge of Buying for all departments in 1958.

The District of Columbia Pharmaceutical Association and Associated Chain Drug Stores were among his pharmaceutical affiliations. He was a Past President of the National Capital Optimist Club, a Trustee of the Boy's Club of Greater Washington, member of the Metropolitan Washington Board of Trade and the Washington Centennial Masonic Lodge.

He is survived by his wife, Eleanor, four sons, daughter and three sisters.

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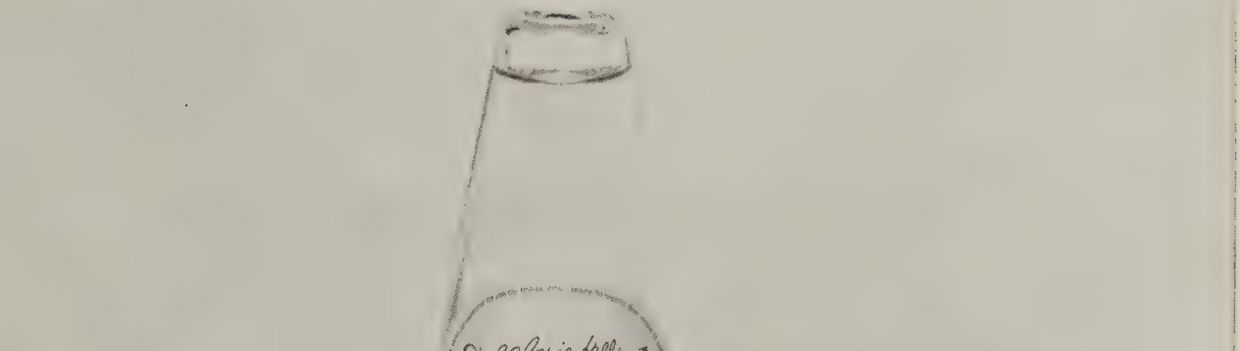
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1882

the maryland pharmacist

Editorial: Unity Now–APhA and NARD

Civil Liabilities of Pharmacists and Pharmacies

Poison Prevention–"Whose Mistake?"

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by B. F. Allen

Volume 45 MARCH 1969 Number 3

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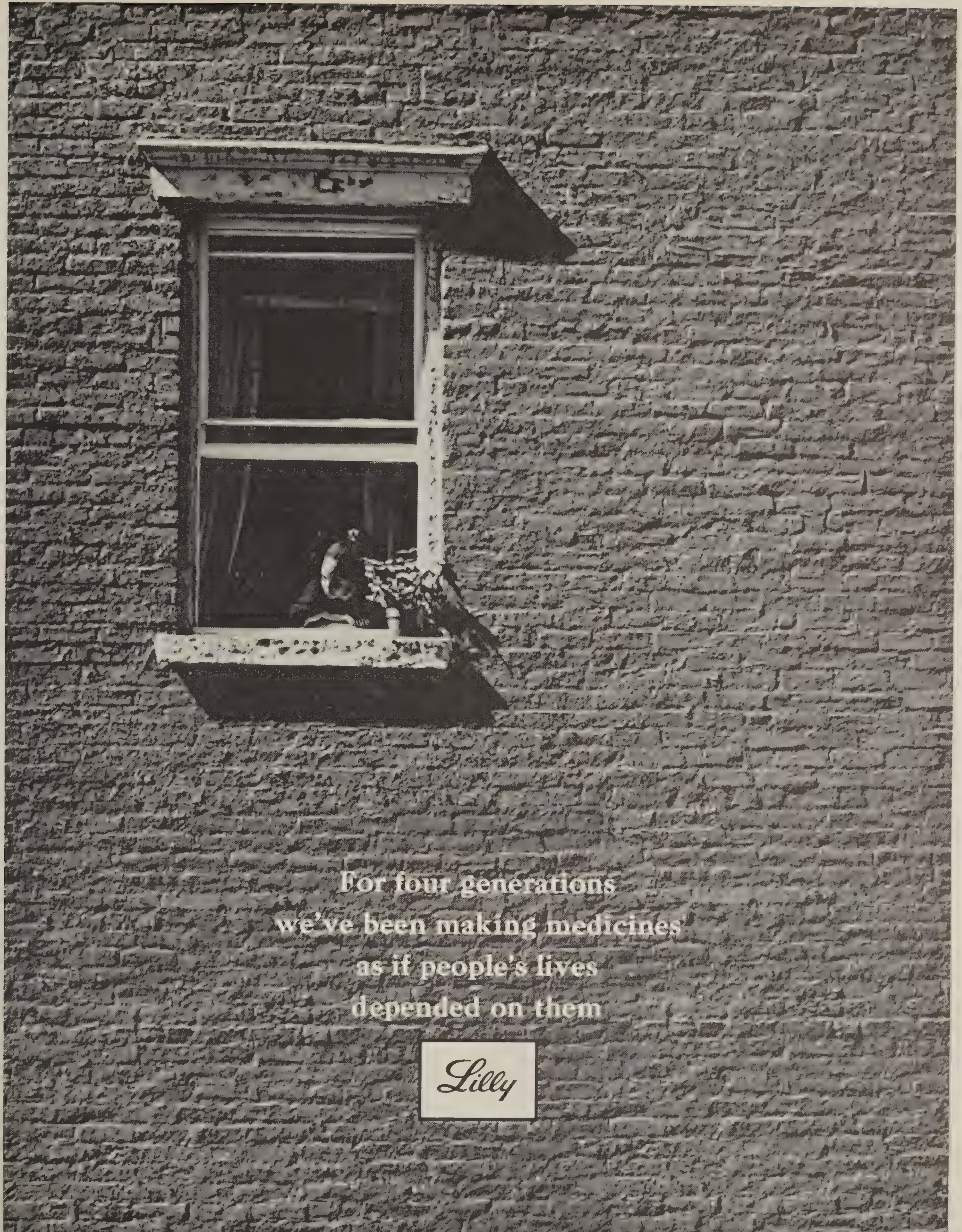
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The Maryland Pharmacist

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MEMBER
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VOLUME 45 MARCH 1969 NUMBER 3

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Editorial . . .

UNITY NOW

The agreement by the American Pharmaceutical Association and the National Association of Retail Druggists to coordinate their legislative efforts in support of Senate Bill 1575, introduced by Senator Philip A. Hart (Dem-Michigan), has been the most heartening news in a long time.

S.B. 1575 seeks to curb physician dispensing, ownership of pharmacies and profiteering on drugs.

Relations between the professions of medicine and pharmacy throughout the nation have been affected for years by the issues of physician dispensing, ownership of pharmacies and profiteering on drugs.

The Maryland Pharmaceutical Association has been able to successfullp curb physician ownership of pharmacies, but this situation wherever it may exist, as well as unwarranted physician dispensing and physician involvement in drug repackaging firms, still remains to be adequately resolved.

It is to the credit of the State Medical Society, the Medical and Chirurgical Faculty of Maryland, that the following position is part of the Physician/Pharmacist Code of Cooperation adopted jointly with the Maryland Pharmaceutical Association:

> The American Medical Association's Code of Ethics states, in part:
>
> > "It is not unethical for a physician to prescribe or supply drugs, remedies or appliances as long as there is no exploitation of the patient."
>
> Notwithstanding this statement, the Medical and Chirurgical Faculty of the State of Maryland believes that drug dispensing by physicians should be discouraged if adequate pharmaceutical service is available. A physician's professional source of income should be from the services he renders to his patients, and only from this source.

Nevertheless, the threat of physician ownership of pharmacies throughout many parts of the nation and the evils of physician dispensing and liaison with some drug repackaging companies, has prompted Senator Philip A. Hart (D-Mich) to continue to seek legislative remedies.

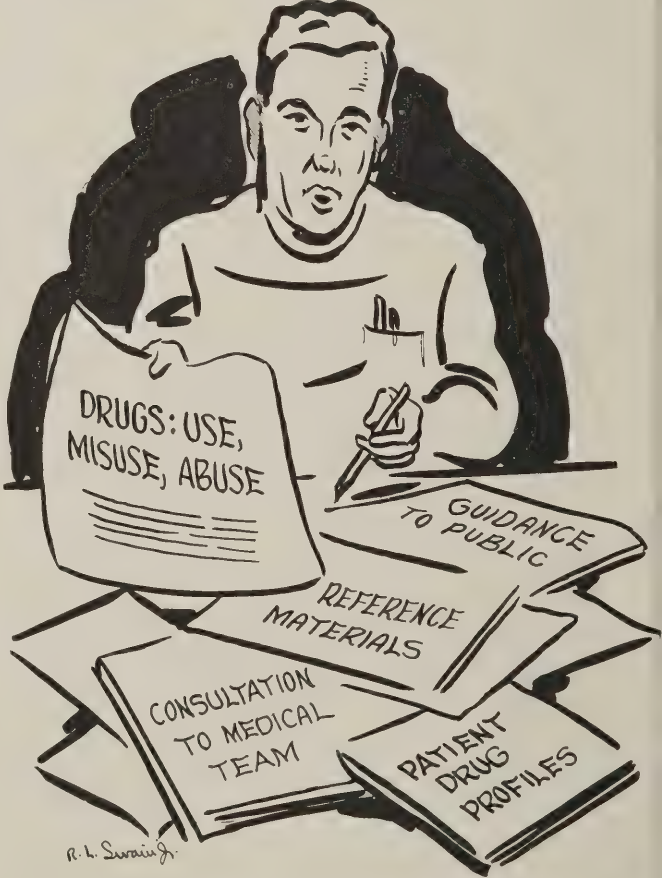
Senator Hart has introduced S.B. 1575 this year in order to eliminate exploitation by some physicians of the pharmaceutical needs of their patients. Fortunately, only a small minority of physicians seem to be involved.

Senator Hart stated that his bill was aimed at wiping out "doctor-merchants—who are having a bad effect on the pocketbook of both patients and independent competitors." The Senator said the goal of the bill is to protect independent competitors from profiteering doctors without stopping doctors from occasionally selling drugs truly as a service to their patients. S.B. 1575 has been referred to the Senate Commerce Committee, and its Chairman, Senator Warren G. Magnuson (D-Wash), is a co-sponsor of the new bill. Maryland Senator Joseph D. Tydings is a member of the Committee.

APhA and NARD agree that passage of the Hart bill is essential for the professional independence of pharmacists.

This demonstration of unity by our two national pharmaceutical organizations indicates that the leaders of pharmacy can work together for a common cause. It is vital that all pharmaceutical associations and all pharmacists do everything possible to obtain enactment of S.B. 1575.

All interested in preserving the integrity of both medicine and pharmacy have a responsibility to help protect the public interest in this matter.



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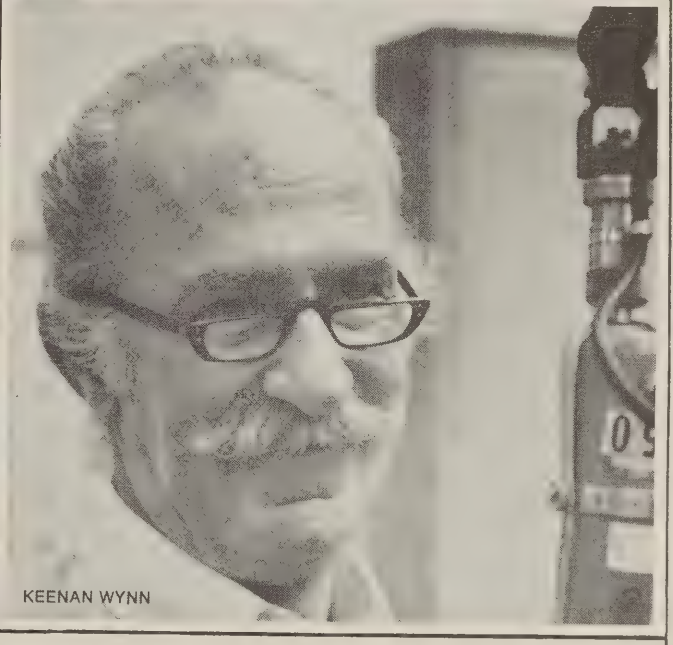

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Maryland Board of Pharmacy News . . .

Civil Liabilities of Pharmacists and Pharmacies

SUMMARY OF DUENSING V. HUSCHER
431 SW 2d 169 (July 8, 1968)
SUPREME COURT OF THE STATE OF MISSOURI

The civil liability which may be incurred by a pharmacy when a prescription is wrongfully filled by an unlicensed individual was dramatically demonstrated in the case of *Duensing v. Huscher,* decided by the Supreme Court of the State of Missouri on July 8, 1968. Damages were assessed against a pharmacy and the unlicensed individual who wrongfully filled the prescription. These damages were in the amount of $22,000 for actual injuries and, in addition, each were assessed $2,500 as punitive damages.

The plaintiff in this case was a minor child whose doctor had recommended aspirin suppositories, a proprietary drug in Missouri, for fever. An employee of the defendant pharmacy, who was not a registered pharmacist, took the call from the doctor, but delivered to the plaintiff's parents, seconal sodium suppositories, a legend prescription drug, which he took from the shelf by mistake. The child suffered barbituate intoxication, was rushed to a Kansas City hospital in a coma, and suffered other injuries from the effect of the drug.

Missouri law provides that layman may fill prescriptions, if it is done under the supervision of a licensed pharmacist. In this case, however, the licensed pharmacist was not on the premises. The defendant argued that since aspirin suppositories are not a prescription drug but a proprietary drug, there was no violation of the law and, in actuality, no refilling of a prescription. The Court held, however, that the employee had removed the original label from the package and prepared a label of the pharmacy with the doctor's directions in regard to the use of the suppositories and that this constituted the filling of a prescription.

It was clearly demonstrated that there was no actual malice or ill-will on the part of the employee who delivered the wrong suppositories to the plaintiff. The Court held, however, that since Missouri law was violated, namely, since a prescription was delivered by an unlicensed individual not under the supervision of a licensed pharmacist, punitive damages were accessible. Punitive damages accessed in the amount of $10,000 against each of the defendants in the lower Court were reduced to $2,500 each by the Supreme Court of Missouri. The total monetary liability for this mistake on the part of an employee was thus fixed at $27,000.

This case not only demonstrates the civil liability to which a pharmacist or an individual may be subjected under the circumstances, but it is a classic illustration of the danger which the public may be subjected should subprofessionals be permitted to practice pharmacy and when the proper supervision is not present.

Forged Prescriptions

The National Association of Boards of Pharmacy brings the following to the attention of all concerned:

There is evidence throughout the United States that the problem of forged prescriptions is of mounting significance. All national associations, state associations, and societies in the health field should be alerted to this problem and, in turn, should do all that they can to alert persons who handle drugs to the mechanisms used to obtain drugs via forged prescriptions which could divert controlled and legend drugs into illegal channels.

One of the solutions suggested by the Bureau for the forgery problem would rest in a program involving pharmacists, health personnel, and law enforcement agencies: city, county and federal. In many instances prescriptions are written on pads or prescription blanks stolen from physicians' offices, from out-patient departments in hospitals, or from physicians' automobiles.

All those who have responsibilities for distribution of prescription drugs should be advised to exercise great care in retaining blanks, either in the physician's office or in areas considered to be reasonably safe.

The following is adapted from a notice from the Utah State Board of Pharmacy:

If you receive what you suspect is a forged prescription for any drug, but especially those which fall under the Drug Abuse Control Act and narcotics; please do any or all of the following:

(1) Ask for indentification of person bringing in prescription and if still not satisfied tell person you believe the doctor erred in writing prescription, then confirm RX with the physician if possible. Retain RX if possible. Write description of suspect and get license number.

(2) Do not jeopardize yourself, but if possible call the police and try to detain suspect.

(3) Tell suspect you are out of stock, but can have on next delivery, notifying him of the time to come back. After he has left notify police.

Talk to all physicians you can asking them to be careful with their prescription pads to prevent theft of them to prevent more forgeries.

The Board would also like to remind you that if you have a theft or burglary of drugs, both State and Federa regulations require that within five (5) days a report be submitted with an inventory as accurately as possible of the drugs stolen.

The Board also suggests you continue to keep accurat accountability records of all HR-2 Drugs and narcotics fo your own protection. Federal inspections in State of Utah show over 10% of those checked were reported for lega action because of improper record keeping.

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Dr. Schaefer Calls For Total Reappraisal of Drugs

In view of the growing problem of drug abuse and misuse, Dr. John F. Schaefer asserted that the total reappraisal of drugs is needed in this country. Dr. Schaefer is Chairman of the Council of the Medical and Chirurgical Faculty of the State of Maryland and former Chairman of the Pharmacy Liaison Subcommittee. He graduated from the University of Maryland School of Pharmacy and holds a B.S. in Pharmacy.

Coordinating the activities of all governmental, professional and other interested groups in the health care field would be a great accomplishment and highly desirable, he indicated.

Drug Abuse

"The public has to realize that all drugs are potentially toxic," Dr. Schaefer said. "Drug Abuse should be equated with the word harm." Physicians were urged never to prescribe a drug without a specific indication and they should stick to a small but quality armamentarium until better drugs come along.

Doctors should re-educate themselves regarding dosage for weight control, control over prescription refills, legislation concerning narcotics and drug abuse drugs, Dr. Schaefer noted.

The Code of Cooperation between physicians and pharmacists in the State of Maryland was hailed by Dr. Schaefer as a milestone in the relationship between the professions. He noted that the Commission on Medical Discipline will go into effect on July 1.

"All drugs are dangerous," Dr. Schaefer told the pharmacists attending the meeting. They were urged to put all drugs and medicinal agents off self service display. The pharmacist should question customers requesting laxatives, stimulants and depressants to assure sufficient knowledge regarding their use.

Drugs Through Pharmacy Only

Another objective placed forward by Dr. Schaefer is to ban the sale of all drugs and medicinal agents anywhere but in a pharmacy in order to provide for better control of the use of drugs.

Dr. Schaefer announced that the Medical Society of the State of Maryland has taken an official position banning the imprinting of prescription blanks with the refill legend "Refill 1-2-3-Prn" at the bottom of the blank. This requires the physician to write refill instructions in longhand. The forgery of refill instructions will be more difficult.

Pharmacists who keep individual patient prescription records were praised. In this manner pharmacists may be alerted to possible drug reactions when dispensing prescriptions.

In his summary, Dr. Schaefer asked, "What can we do to control drug abuse, drug dependence and over medication? There is but one answer, he declared . . . education . . . education of the public, physicians and pharmacists."

Dr. John F. Schaefer (center) with Melvin N. Rubin, AZO Kappa Chapter President (right) and Bernard B. Lachman, President, Baltimore Metropolitan Pharmaceutical Association.

The Student Committee on Drug Abuse Education of the University of Maryland, School of Pharmacy was complimented for its participation in the drug abuse problem.

Dr. Schaefer made his presentation at the January breakfast meeting of the Kappa Chapter of the Alpha Zeta Omega Pharmaceutical Fraternity, with Melvin N. Rubin, chapter president, presiding.

In attendance at the breakfast meeting were Dr. William J. Kinnard, Jr., Dean of the University of Maryland School of Pharmacy; Nathan I. Gruz, Executive Secretary of MPhA; Bernard B. Lachman, President of BMPA. and Paul Reznek, Secretary of the Prince Georges-Montgomery County Pharmaceutical Association, also representing Pi Chapter of the fraternity.

Cyclamate Safe Usage Levels

Adult use of 5 grams or less per day of cyclamate should not present a hazard to its users, a committee of the National Academy of Sciences-National Research Council has reported to the Food and Drug Administration.

The committee suggested that acceptable consumption levels of artificial sweetners should be based on body weight and concluded that daily intakes of 70 milligrams of cyclamate per kilogram of body weight are safe.

A limit of 50 milligrams per kilogram per day has been suggested by the Food and Agriculture Organization and World Health Organization of the United Nations.

The FDA considers it prudent for consumers to adhere to the levels recommended by FAO/WHO—50 milligrams per kilogram of weight per day—FDA Commissioner Herbert L. Ley, Jr., M.D., said pending results of research now under way.

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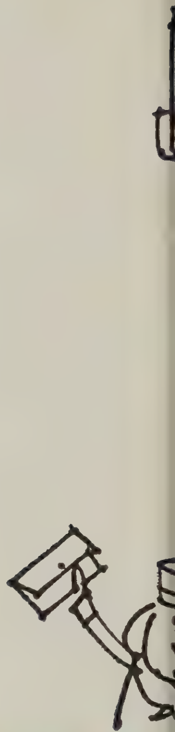

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News Of The Industry . . .

CALVERT DRUG CO.

Frank J. Macek, long-time director of the Calvert Drug, resigned from his post. Donald O. Fedder was appointed by the Board of Directors to the unexpired term.

The present officers and directors are: President, Harry L. Schrader; Vice-President, Gordon A. Mouat; Secretary, Frank Block; Treasurer, Norman J. Levin; and Assistant Treasurer, Anthony G. Padussis. Directors: Simon Solomon, Irving I. Cohen, James P. Cragg, and Donald O. Fedder.

MULITZ VICE PRESIDENT DISTRICT WHOLESALE DRUG

District Wholesale Drug Corp. (Washington, D.C.) subsidiary of Spectro Industries announced the appointment of Mr. Benjamin S. Mulitz as Vice President—Operations.

Since joining the company in 1955, he has served in the capacity of System Director, Sales, Data Processing and Operations. Prior to 1955, he was employed as a manager of retail pharmacy.

Mr. Mulitz is a member of the District of Columbia Pharmaceutical Assn. serving on various committees, is now serving as Chairman of the DCPhA Convention to be held this June 1969, is a member of the Prince Georges-Montgomery Co. Pharmaceutical Assn. serving on the Executive Committee ex-officio, member of the Potomac Pharmaceutical Assn. and Past President of and currently serving as Secretary-Treasurer of the Travelers Auxiliary of the Washington Metropolitan Pharmaceutical Assn.

NEW PRODUCT: YOUNG'S BIDETTE MIST

Youngs Drug Products Corporation, a firm dedicated to the distribution of health products *through pharmacies only*, announced a new product—BIDETTE Mist.

A special formulation that deodorizes the outer vaginal area, BIDETTE Mist is designed as the modern convenient way to complete feminine hygiene and personal assurance. The product is available in regular 5-ounce size and 3/4-ounce purse size.

MILTON ELSBERG REAPPOINTED TO BOARD OF BRAND NAMES FOUNDATION

Milton Elsberg, President, Drug Fair Stores, Alexandria, Virginia, has been re-appointed to serve on the Board of Directors of Brand Names Foundation until the 1970 Annual Meeting. Elsberg represents the National Association of Chain Drug Stores, Washington, D.C.

Brand Names Foundation is a non-profit membership organization founded in 1943 and dedicated to maintaining and strengthening the brand competitive system.

Members of the Foundation are the makers of leadership brands in all categories of consumer products, advertising agencies and media. The programs of the Foundation reach and inform consumers and the retailing industry.

ARTHUR PELLEGRINO DRUG HOUSE PRESIDENT

Arthur J. Pellegrino serves as President of The Drug House, Inc., succeeding H. C. Van Arsdale who retired last November. Mr. Van Arsdale has remained as a consultant to the Philadelphia-based wholesale drug firm.

Mr. Pellegrino joined The Drug House, Inc. in January, 1968 as Executive Vice President, having been previously associated with Smith Kline & French Laboratories and later serving their Menley & James Laboratories Division as Vice President of Sales. He is a graduate and a member of the Board of Directors of Temple University College of Pharmacy.

He and his wife, the former Claire Picarello, live in Plymouth Valley, Pa. with their two children—Barbara, 17 and Arthur, Jr. 11.

GILPIN SALES AND EARNINGS

Advances in sales and earnings for the fiscal year 1968 from all operations were reported by James E. Allen, Chairman and President of The Henry B. Gilpin Company. Consolidated sales set a new record, totaling $31,518,020, up 7.7 percent from $29,264,792 in 1967. Net earnings after taxes amounted to $264,550, representing a 58 percent increase over the previous year. Earnings for 1968 were equal to $2.94 per share on the Class A, Common and $2.12 per share on the Common.

Mr. Allen stated that Gilpin is making sound progress in its program for diversification in the marketing of health care products and computer services. During the year, Gilpin acquired all of the outstanding stock of McKenna Surgical Supply, Inc. of Arlington, Virginia—a full line and full service hospital and surgical supply house. The Gilpin Computer Center in Washington, D.C. has expanded its facilities and personnel and is entering the computer time and service business.

ARMSTRONG CORK NAMED PALM-N-TURN DISTRIBUTOR

The Med-A-Safe Division of Hayes-Albion Corp. has appointed Armstrong Cork Co. a national distributor for its complete line of "Palm-N'-Turn" child-resistant prescription containers, it was announced today by Carl W. Cooke, vice-president and general manager of the Med-A-Safe Division.

"With Armstrong as national distributor for 'Palm-N'-Turn' we will have the benefit of 300 wholesalers and 1700 salesmen offering a total program of plastic and glass safety containers for distribution to the drug trade," he said.

Armstrong is a major manufacturer-distributor of pharmaceutical containers. The Med-A-Safe Division of Hayes-Albion is the world's largest manufacturer of child-resistant prescription containers, now being used by more than 12,000 chain and independent drug stores and all U.S. Military installations.

"Palm-N'-Turn" containers have a unique self-locking cap which is child-resistant but easy for adults to open. When the cap is pressed in the palm of the hand, a springy disk inside is depressed, freeing notches from lugs on the vial. A slight turn then easily removes the cap.

DISTRICT WHOLESALE MERGER

The merger of three drug wholesale companies into Spectro Industries, Inc., was announced by Joseph L. Garde, president. The three merged companies, publicly-owned District Wholesale Drug Corporation of Washington, D.C., West Wholesale Drug Company of Philadelphia, Pennsylvania and Massachusetts Wholesale Drug Company of Springfield, Massachusetts, both privately-owned, will be operated as wholly-owned subsidiaries of Spectro. Spectro had sales of approximately $65 million for the fiscal year ended 1968.

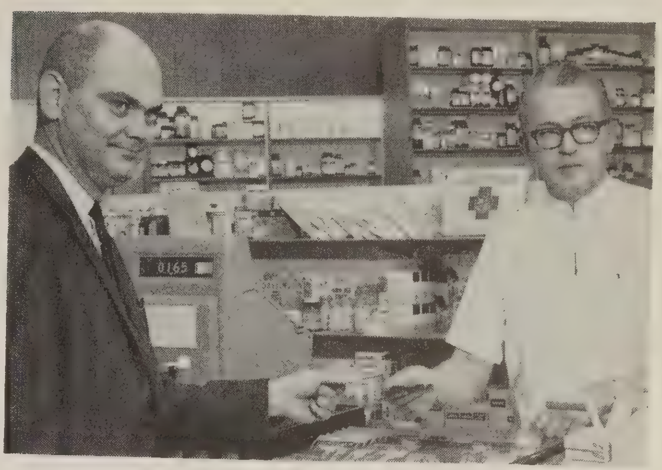
Mr. Garde said "The merger was conceived to create a versatile, comprehensive service organization. We expect to benefit greatly from efficiencies gained through combined operations and experience."

The new firm operates in Connecticut, Massachusetts, New Jersey, Pennsylvania, Delaware, Maryland, Virginia and the District of Columbia, serving over 3300 retail pharmacists, hospitals, clinics, department stores and governmental institutions. Its wide range of products include ethical drugs, proprietary medicines, cosmetics and toiletries, home health aids, convalescent and hospital supplies, candies, tobacco items and other house, garden and sundry items.

"The new company will pursue a major expansion program, particularly in the fields of leasing, data processing, hospital supply, drug wholesaling, surgical instruments and other fields," Mr. Garde said. As part of its expansion program, Loewy Drug Company, Inc., a division of Spectro's District subsidiary, has established a new, ultra-modern 90,000 square-foot distribution center in Baltimore.

Spectro's present operational spectrum includes wholesaling, data processing, consulting services and financial aid to retail customers. Extensive computerization for inventory control and related uses, already underway at West before the merger, are contemplated for all Spectro subsidiaries.

First Blue Cross Prescription Check



Pharmacist Henry J. Glaeser, Jr., proprietor of Manchester Pharmacy in Carroll County, received the first check for payment under the Maryland Blue Cross Prescription Program from Stuart L. Baltimore, Jr., Manager Pharmacy Relations of Maryland Blue Cross.

RESEARCH AT UPJOHN

Upjohn has filed a new drug application for Dalacin C, an antibiotic. One interesting sidelight of this compound, is its effect in animals on the treatment of malaria.

In the contraceptive field, Upjohn markets an oral contraceptive and is awaiting FDA approval for its injectable, "for which we have considerable hope." Research is actively exploring other possibilities, R. T. Parfet, Upjohn President and General Manager, noted:

"Our people have done work on male contraception . . . And it has been extensively reported that we are working with a new group of compounds called prostaglandins, one of which may have interesting contraceptive possibilities."

He revealed that Upjohn researchers have been able to develop a non-combustible version of its proprietary urethane "overcoming one of the last major obstacles to its acceptance as an insulation material in all types of construction."

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Poison Prevention Activities

Accidental poisoning reports from the 22 hospitals and clinics in Baltimore that treat poisoning cases reveal that 3,775 persons were victims in 1968. This represents an increase of 14 cases over 1967. Although this report does not include poisonings treated by private physicians or by first aid at home, it does show significant trends in accidental poisonings in the city.

The number of poisonings attributed to internal medicines was reduced in 1968. Although still leading the list of poisoning agents with 2,555 cases, internal medicine poisonings were 50 fewer than in 1967. Aspirin, however, still leads the list in this category with 928 cases. The next highest group of poisoning agents was household preparations such as washing and cleaning products, pesticides, cosmetics, polishes, paints and solvents, with 840 cases. Here again the total was less than in 1967 by 65 cases.

There was a noticeable increase in drug abuse poisonings in Baltimore however. A further study of internal medicine poisonings showed a total of 895 cases attributed to overdoses of sedatives, stimulants, narcotics and psychopharmaceuticals. While the preschool child 1-4 years old is the leading victim of accidental poisonings with 2,169 in this age group reported, those from 12 to 24 years of age were second with 550 cases, chiefly due to accidental poisonings through drug abuse. Further, a report of resident accidental poisoning deaths from the City Health Department's Bureau of Biostatistics shows that of 43 such deaths in 1968, 40 were from overdose of narcotics or sedatives.

Plans for poison prevention in the Baltimore area were formulated by a Poison Prevention Committee for National Poison Prevention Week in March. This committee comprises representatives of the Maryland State Department of Health, the Baltimore City Health Department, the Maryland Pharmaceutical Association, the Maryland Academy of Pediatrics, the Baltimore Safety Council and the Federal Food and Drug Administration.

CITY OF BALTIMORE
1797

Paramount Photo Service

Mayor Thomas J. D'Alesandro, III, signs proclamation for National Poison Prevention Week in Baltimore. BMPA President Bernard B. Lachman (right) looks on with Dr. Mary S. Furth, Director of the Maryland Poison Information Center and Executive Director, Nathan I. Gruz.

WHOSE MISTAKE?

Pharmacists and Poison Information and Control Personnel Please Take Note

DR. MARY STANG FURTH, *Director*
Maryland Poison Information Center

The following letter was sent from the Maryland Poison Information Center this week to personnel at Poison Control Centers.

An incident happened at the Maryland Poison Information Center on March 5, 1969. This incident could have proved quite disastrous and, therefore, I would like to alert everyone concerned.

A parent called the Information Center because her 2 children had ingested a quantity of adult aspirin. The parent was asked if she had Ipecac. Because one of these children had been treated for poisoning before, the parent had been instructed to have Ipecac at home. She had procured a bottle as she had been instructed, so that when asked by us if Ipecac was in the home, she said yes. She was instructed to give one tablespoon of Ipecac, as our usual procedure, and force fluids. Six hours later, the parent called the Center because the children were continuing to vomit profusely. Detailed further inquiry revealed that the children had not been given *Syrup of Ipecac,* but *Fluid Extract of Ipecac.* The mother related that she had been instructed to get Ipecac, and procured it from a pharmacist about a year ago. The pharmacist gave her *Fluid Extract* instead of the *Syrup.* Much endeavor has been promoted in getting this fluid extract off the market for use in homes and out of the E.R. There is no reason for using Fluid Extract under any circumstances. Fortunately, the children had only been given a teaspoon instead of the tablespoon that should have been given of the syrup. Fluid Extract of Ipecac is about ten times more potent than the syrup of Ipecac, and an ounce is known to be fatal in an adult.

The purpose of bringing this to your attention is to make you more alert, and to be sure that if a parent has Ipecac in the home or is going to procure it, that it be the *Syrup of Ipecac.* It may be necessary to orient oneself to require that the parent or other telephone inquirer read the label to you over the telephone. I cannot stress this too much. Please be alert!

As one becomes aware in reading this, there are many people involved in letting this hazard continue. Whose mistake? Was it the pharmacist's that gave the Fluid Extract of Ipecac? Was it the physician who told the mother to get the Ipecac? Should the parent have had it in her home? Should the Poison Control Officer's inquiry been more specific about what product the parent had on hand? Many fingers would have to be pointed if one was to accuse anyone of this incident of negligence. But I think you, as pharmacists, should be alerted that your shelves should go under strict scrutinization and Fluid Extract of Ipecac be placed on the list of products that should be taken off the usual shelves and be handled with great caution.

It is our feeling there is no need for the Fluid Extract of Ipecac to be used, since many manufacturers are already preparing the Syrup for distribution to the various apothecary shops. I implore you to take note and take every measure you can to prevent another incident such as this.

Secretary's Script . . .

Governor Marvin Mandel, center, presented Proclamation on Poison Prevention Week to MPhA President Samuel Wertheimer with Executive Secretary Nathan I. Gruz on right.

altimore County Executive Dale Anderson presents proclamation n Poison Prevention Week to BMPA President-elect, Anthony G. adussis, second from the right. Looking on are Dr. Donald J. Roop, hief County Health officer on left and Dr. John M. Krager, ssistant Health Officer and Director, Bureau of Health Supervision.

Union Prescription Plans

Representatives of the Maryland Pharmaceutical Association under Morris Bookoff, Chairman, Subcommittee, Prescription Prepayment Plans, have been working with Benjamin E. Jaffe Associates of the Retail Clerks Union Drug Plan attempting to improve every aspect of this prescription prepayment plan.

We trust that by working together we can secure a plan that will best meet the needs of patients (union members) and the administrators as well as the participating pharmacists.

We believe that during the coming months a number of important improvements will be achieved and announced to you.

Your cooperation is urged for the mutual benefit of all concerned by promptly returning the questionnaire mailed to participating pharmacists regarding imprinters.

NARD Convention, Las Vegas—October 12-16

Members of MPhA planning to attend the NARD convention in Las Vegas should contact the Association office as they are eligible to be appointed delegates.

Special arrangements have been made for a package deal via United Airlines Charter and Caesar's Palace. Contact Singer Travel Agency, 655-1000 for details.

Mandatory Continuing Education

Should a pharmacist be required to fulfill minimum continuing education standards in order to receive re-registration of his pharmacist's license to practice?

Let your Association know your views. Mail your opinions on this and other controversial issues to the MPhA office, 650 West Lombard Street, Baltimore, Maryland 21201.

Sincerely,

Nathan I Gruz

Executive Secretary

Some Practical Pharmaceutical Applications Of Carbopol 934

by B. F. Allen, Ph.D.

Associate Professor of Pharmacy
University of Maryland, School of Pharmacy

In recent years, a great number of dispersing and suspending agents have appeared on the market. In fact, there are so many of these so-called "aids" available that there is as much confusion in the trade about them as we in pharmacy experience with ethical specialties, proprietaries, generics, and official names. For my assignment I was asked to present just one of these "aids," namely Carbopol 934, which has actually been available to us for some time.

Product progress does not always develop according to plan. Long years of work and study on high polymers and chemical synthesis at B. F. Goodrich Chemical Company (Cleveland, Ohio) created the know-how and raw materials for a field always of interest — water soluble resins.

A search for suitable applications was then begun, but the real breakthrough did not arrive until 1950. Two BFG workers had a chance meeting with a stranger looking for a reliable postwar source of gum karaya (sterculia gum) used in denture adhesive.

A carboxy vinyl polymer was suggested (an example is the polymer of acrylic acid $CH_2=CHCOOH$) as a substitute for the gum karaya, and within two months a compound was ready. The new polymer was ideal for the adhesive technically, but not commercially. An intensive search for new uses was on. Next it was tried in toothpaste to replace gum tragacanth, but failed technically.

The first major use was as a bulk laxative. This application was permitted by the FDA after safety of the product had been demonstrated by toxicity studies and clinical trials. (It was advertised as suitable for oral drug use in the Drug and Cosmetic Industry Journal, June 1956). Its effectiveness in this application was outstanding, even for bedridden patients. At this time the material became known as "Carbopol."

Although this synthetic polymer sold by the name of Carbopol 934 has excited considerable interest in drug circles as an emulsifier, thickener, suspending agent and transitional colloid, literature supplied by the manufacturer does not state the exact chemical composition of the material.

The chemical structure and the significance of the number 934, evidently, are secrets of the manufacturer. The latter simply states that chemically, Carbopol 934 (hereinafter designated as Carbopol in this paper) is a carboxy vinyl polymer of extremely high molecular weight and supplied in the free acid form.

Carbopol is not subject to hydrolysis or polymeric degradation due to bacterial or fungal attack. It is a finely divided, free flowing white power. Like many other powders, it tends to form clumps of particles when haphazardly dispersed in water. A 1 per cent dispersion in water shows a pH of about 3 and yields a cloudy solution of low viscosity. When this solution is neutralized with an appropriate alkaline substance (for example sodium hydroxide), the solution is transformed into a clear product generally called a gel.

Several studies have been undertaken to determine the suspending and emulsifying properties of Carbopol in combination with various medicinal agents. Experience has shown that up to 50 per cent of some water immiscible materials can be emulsified using Carbopol solution without any neutralizing agent. For example, an emulsion of 50 per cent mineral oil can be prepared by adding the mineral oil to a 1 per cent unneutralized Carbopol solution.

It has been reported that Carbopol lends itself well to the preparation of pharmaceutically elegant and stable formulations of a number of commonly prescribed medicaments. Dermatological preparations containing Carbopol, when applied to the skin, generally rub in well and do not feel greasy or sticky. In addition, such products allow ready absorption of the medicament and easy soap and water removal from the skin.

The following formulas have been suggested in the literature as having produced highly satisfactory preparations. It is well to remember, however, that results can be materially affected by differences in the purity of materials being used, rate and manner of addition of the constituents, and many other variable factors. Therefore, these formulae should be regarded only as guides.

Ephedrine Nasal Gel

Ephedrine alkaloid	1.0
Carbopol	1.0
Eucalyptol	0.1
Methyl salicylate	0.01
Dwarf pine needle oil	0.01
Alcohol	2.0
Water	96.0

Kaolin-Pectin Suspension

Kaolin	19.8
Pectin	0.4
Carbopol	0.3
Sucaryl sodium	1.0
Peppermint oil	0.5
Methyl salicylate	0.5
Sodium carbonate	0.2
Water, q.s.	100.0

Calamine Lotion

Calamine	8.
Zinc oxide	8.
Glycerin	4.
Neutralized carbopol mucilage (0.5 per cent), q.s.	100.

Zinc Oxide Ointment

Water	76.
Carbopol	0.8
Sodium hydroxide solution (10 per cent)	3.2
Zinc oxide	20.

Tooth Paste

Sorbitol solution (70 per cent)	24.1
Sodium saccharine	0.2
Sodium lauryl sulfate	1.8
Carbopol dispersion (6 per cent)	15.0
Water	12.1
Spearmint oil	1.0
Sodium hydroxide solution (50 per cent)	0.8
Dibasic calcium phosphate	45.0

Carbopol water-soluble resin is an ingredient in the following commercial preparations:

BRASKA (DRUGMASTER, INC., ST. LOUIS, MO.) gel form analgesic lotion contains methyl nicotinate, glyco monosalicylate, methyl salicylate, salicylamide, camphor menthol, and isopropanol.

CARA NOME HAND LOTION (REXALL DRUG CO., LOS ANGELES, CALIF.)

COLOGNE GELEE (REXALL DRUG CO.) new concept in fragrance, a sparkling brilliant, non-running, non-dripping perfume, when rubbed on the skin produces an imperceptible residue that is free of stickiness.

GRIN (BARBASOL CO., INDIANAPOLIS, IND.) after-shave lotion "with talc built in," provides a two-in-one treatment and gives the same effect as applying talcum powder separately after applying a lotion.

HEXA-GERM (HUNTINGTON LABORATORIES, HUNTINGTON, IND.) creamy antiseptic skin detergent used in hospitals for pre-surgery hand and patient wash-ups, contains hexachlorophene, lanolin, petrolatum and other ingredients.

KUL-FUT (KUL-FUT LABORATORIES, HOLLYWOOD, CALIF.) lotion applied to tired aching and burning feet, contains turpentine oil and other ingredients.

KUTOL NO. 140 *WATERLESS HAND CLEANER* (KUTOL PRODUCTS CO., CINCINNATI, OHIO) lotion can be used with or without water by workers in garages, printing plants and other dirty hand operations. Leaves hands feeling clean and natural without stickiness or drying out.

TEN-O-SIX COOL GEL (BONNE BELL COSMETICS, CLEVELAND, OHIO) burn remedy with fast-action relief and slow-motion drying.

THERMO-JEL (FARWELL PHARMACEUTICALS, INC., NORMAL, OKLA.) gel for relief of aching muscles and pains of rheumatism and arthritis, contains isopropanol, menthol, allyl isothiocyanate and methyl salicylate.

THRU ANALGESIC JEL (REXALL DRUG CO.)

VETERINARY PRODUCTS (RESEARCH LABORATORIES, INC., ST. JOSEPH, MO.) include a highly palatable nutritional supplement for pigs; preparation for treating upset stomachs of dogs and cats; and creams, jellies and liniments for external use.

WATERLESS HAND CLEANER (FURST-McNESS CO., FREEPORT, ILL.) cream removes grease and grime—even tar or paint—and leaves hands feeling soft and smooth.

Carbopol used in the above mentioned commercial products for the following reasons: (1) in lotions to obtain excellent suspension and emulsion stability; (2) in creams since the preparation may be used in areas where temperatures are high—or cold, resistance is provided to viscosity changes or emulsion breakdown; (3) topical application of gel base turns preparation to a liquid releasing the active medication to penetrate into the skin giving the desired beneficial effect; (4) gel-like lotions are non-standing, slow evaporating, unaffected by aging; (5) an excellent bulking agent; (6) controlled release of fragrance; and (7) can be packaged in a tube as well as in a bottle, either plastic or glass.

cosmetic corner

BY ELOISE SOPOCY

The sale of eye products has increased greatly during the past two years and this trend is expected to continue in 1969. More eye products are being sold, but unfortunately, in many pharmacies, these sales are limited to eye make-up and artificial lashes.

Are you being as careful to recommend proper care for the eyes and eye area as you are to sell adornments?

Most of you are aware that the area around the eyes is very sensitive and delicate. It is in this area that "age lines" first appear. There are no oil glands in this thin skin. So from a rather early age, a person should be providing for good care of the eye area.

The key rule for taking care of this area is *regularity* and *gentleness*. Too much pulling and stretching can tear this skin out of shape. Recommend an eye cream to your customer that is rich in emmollient oils and that she will be able to apply gently. (You might remind her that to make a face look older on stage, make-up artists add lines around the eyes. But, the make-up comes off as soon as the play is over.) Impress upon your customer that daily use of the eye cream will pay off; however, she can't expect to use it every two weeks or so and do much good.

Encourage any customer wearing eye make-up to remove the make-up gently, preferably with special remover pads. These pads not only cleanse the eye area gently and thoroughly, but they also help lubricate the skin.

Encourage your sun-worshipping customers to use eye cream under their sun glasses.

Do you stock eye compresses, those pre-saturated eye pads that make tired eyes feel so much better? Do you feel that eye drops are a part of the beauty routine?

I am sure you remember that men's eyes get tired and full of dust and soot too. Have you seen the eye drops designed just for men? The bottle even has a silver cover to protect it and beautify it in the man's pocket.

Encourage all your customers, both men and women, to exercise their eyes. Probably the simplest exercise is to roll the eyes. Look down as far as possible, to the right as far as possible, up as far as possible, and to the left as far as possible. Incidentally, this exercise is very good for relieving strain and tension.

Most men believe a women's eyes are one of her most important features. They should be their most attractive. This means not only must the eye make-up be properly applied, but the eyes must sparkle and shine. And the area around the eyes must be smooth and youthful looking.

You can help every one of your customers look her best.

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L.A.M.P.A. Report

Anne Crane, *Corresponding Secretary*

January 21, 1969 dawned rainy and cold, with a forecast of more rain. Undaunted, however, LAMPA's first mini-tour proceeded, as scheduled. At 9:30, everyone being on time, 34 ladies and one gentleman (Mr. Mattie Palmer) boarded our chartered deluxe bus and we were off to the Flag House. This is the house in which Mrs. Mary Pickersgill made the flag which Francis Scott Key saw flying over Fort McHenry in 1814. In the kitchen, a collection of old irons, for pressing clothes, was on special display. As we passed through each room, it unfolded its particular treasure: Spode and Lowestoft china, Waterford crystal, sunglasses (circa. 1814), and a display showing the evolution of the American Flag. Time passed too quickly, and even though we all could have browsed a little bit longer, we were anxious to stay on schedule.

Our second stop, was the Lloyd Street Synagogue, erected in 1845. The first synagogue in Maryland, it was literally brought to life by the excellent commentary provided by Mrs. E. B. Hirsh of the Jewish Historical Society, a very knowledgeable and a relaxed speaker. The museum, classroom, matzoh oven and ceremonial baths, all received our careful scrutiny. We left, feeling we had taken a capsule course in comparative religion.

The Brentwood Inn, was our champagne lunch and recreation stop. Upon entering the private dining room, each mini-tourist selected a "loot bag" which was filled with many items for travel. Each bag contained an equal number of items, but not necessarily the same things. Before eating, our President, Mrs. Harry Schrader warmly welcomed the members and their guests. The invocation, which seemed especially meaningful, was pronounced by Mrs. Manuel Wagner, our Membership Treasurer. With champagne glass raised, Mrs. H. Sheeler Read, Board Member proposed a toast, which translated from the Spanish—wished us health, and wealth, but most of all—time—to enjoy them. A delicious lunch, with a "scrumptious" dessert followed.

At this point, Mrs. Charles Spigelmire, First Vice President, took over. We had prizes galore—all carefully selected and travel oriented. We took note of a birthday, those planning trips to Spain and Israel and the member with the most guests. It was fun—and we continued our give-away, with prizes inspired by items in our loot bags and later, from articles in our personal handbags. Yes, our gentleman guest won a prize too. A crowd pleaser was the homemade dust cloth, which each one received, with the suggestion—"Don't let our friendship get dusty." LAMPA's thanks to Mrs. Alexander Ogrinz and Mrs. Jerome Cermak, who attended a "Trimming Party" which did just that—trimmed the edges and the appliqued motifs. Obviously, much time, thought and originality was demonstrated in getting together this portion of the program.

Running between rain drops, clutching our loot bags, again we climbed aboard, for the scenic ride along the waterfront area, Fells Point and old industrial southeast Baltimore. The shipping strike enhanced our tour by allowing us to see many more foreign ships, in port for the duration.

Still in the rain, but on schedule, we pulled up to the Mt. Clare Mansion in Carroll Park, Baltimore's oldest house, built in 1854. Here we oh'd and ah'd at the darling doll house on exhibit. Also, the fabulous dinner table, set with old Waterford crystal, unusual silver flatware and a gorgeous silver epergne for the centerpiece. Another item that caught our fancy here was the marrow spoon—an odd shaped spoon used to remove marrow from bones. Beautifully maintained furniture and exquisite china were everywhere. We heard about the origin of the powder room—our colonial forefathers actually powdered their wigs in small ante rooms, off the bedrooms. In the brick floored kitchen, we were shown an old meat scale which was donated to the Mansion by Mr. and Mrs. Harry Schrader. The antique clocks, still keeping time, signaled that our tour was drawing to an end.

At the Stadium parking lot, our happy explorers, a little tired but more informed, said their good byes and started for home. It was a delightful day—in spite of the rain.

Prince Georges-Montgomery County Pharmaceutical Assn.

The Prince Georges-Montgomery County Pharmaceutical Association elected officers for 1969-70 at its general membership meeting Tuesday, March 11, 1969. The following were elected:

President	Paul Reznek
Honorary President	Morton J. Schnaper
1st Vice President	Rudolph F. Winternitz
2nd Vice President	Martin Hauer
3rd Vice President	Louis N. Nobel
4th Vice President	Leonard E. Sogoloff
Secretary	D. J. Vicino
Treasurer	Edward D. Nussbaum

Ervin M. Koch was elected Chairman of the Executive Committee, with the following elected for three years: Paul Bergeron II, Gabriel E. Katz, Sidney Glashofer; for two years: Melvin J. Sollod, Alan B. Berger, N. W. Chandler; for one year: Matthew J. Nevins, Ryland D. Packett, Richard D. Bayliss. Ex-officio members are: Ben S. Mulitz, J. Carroll Benson, Jr., and Joseph I. McKenna.

Also on the program were Dr. Richard A. Hall, Pharmacist, U.S. Public Health Service, National Clearing House for Poison Control Centers, on the subject of "Toxicology of Poisoning Accidents," and Mr. Julian Morris, Information Specialist and Editor of National Institutes of Health News, on the subject of "Highlights of the National Institutes of Health."

LET'S TALK DOLLARS AND SENSE

Profit is the name of the game. And what you as a business man should be concerned with is product profitability. Let's talk dollars and cents about paperbacks and magazines.

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Magazines, paperbacks, comics and children's books also build traffic, lead to related sales, dress up your store and advertise all the products you carry.

It's simple and direct. No charts, no graphs, just plain dollars and sense.

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"Plan For The Future"

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We invest 2% of your monthly purchases for you—
We pay the administrative charges for you—
You select either periodic or lump-sum payments—
Your savings can be collected at any time—
Ten consecutive years of service—

Developed by
THE DRUG HOUSE, INC.

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THE FIRST PENNSYLVANIA CO.

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SMITH BARNEY & CO.

THE DRUG HOUSE, INC.

PHILADELPHIA **TRENTON** **WILMINGTON**

Be Smart!

Stock the One and Only—

Original "SAFETY TIPS"

Think Smart!

Always Sell Them

Smart Users Ask For Them By Name

AMERICAN HYGIENIC CO.

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Represented by

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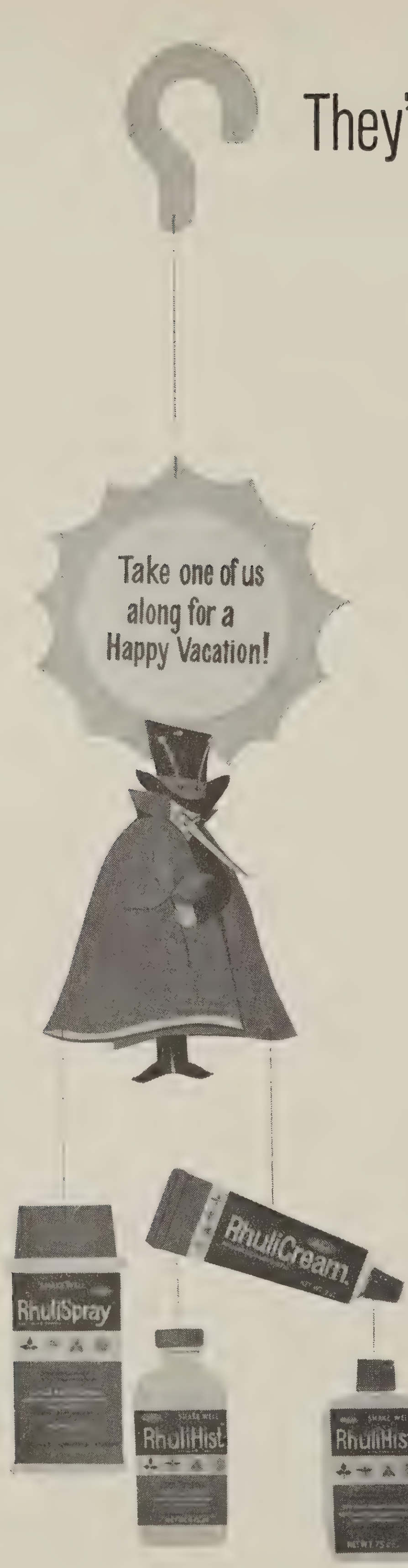
Take one of us along for a Happy Vacation!
RhuliCream
RhuliSpray
Shake Well
RhuliHist
RhuliHist

They're coming!... the customers who'll be asking:

"What's good for...

poison ivy...
mosquito bites...
poison oak...
chigger bites...
little skin irritations,
etc., etc., etc.?"

You'll have a good answer if you stock up with

RHULICREAM®
RHULISPRAY®
RHULIHIST® Lotion

It's Rhuli-deal time.
See your Lederle salesman for details.

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Lederle

499-9

LACTINEX®

TABLETS & GRANULES

- **to help restore and stabilize the intestinal flora**
- **for fever blisters and canker sores of herpetic origin**

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(LX-05)

References:
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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Borden's
ICE CREAM
675-0171

Make Ice Cream Your Favorite Dessert

Hendlers
The Velvet Kind
ICE CREAM

First name in ice cream
for over a half-century

675-6000

MARYLAND PHARMACEUTICAL ASSOCIATION
1882

the maryland pharmacist

Editorial: Maryland's New Health Laws

Advertising under Maryland Pharmacy Law

Swain Pharmacy Seminar

Volume 45 APRIL 1969 Number 4

Compliments of

Noxell
CORPORATION

Makers of

NOXZEMA SKIN CREAMS

NOXZEMA SHAVE CREAMS

and

COVER GIRL PRODUCTS

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Lilly

Your written guarantee of quality

Each prescription you fill is an exercise of your professional judgment. The drug you dispense may be vital to your customer's health and well-being. Minor differences in dosage form, particle size, solubility, rate of absorption, or hardness of tablet can make major differences in therapeutic efficacy. When the choice is yours, you want to dispense the best.

Lilly

900326

Eli Lilly and Company • Indianapolis, Indiana 46206

60,000,000
vacationers to
hit the road
this summer

Good News

about products & profits from A. H. Robins

Forecast:
Hot deals
followed by
heavy buying

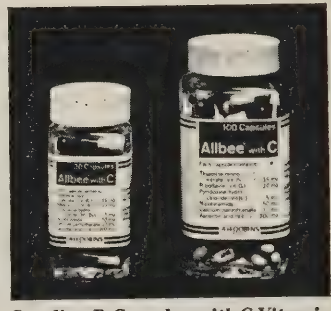
TWO NEW DEALS!

Donnagel® Deal Made to Order for Summer Diarrhea

A Good Traveling Companion

During April and May druggists all across the country will be able to purchase Donnagel at special bargain deal prices. What better time to stock up on the outstanding medication for traveler's diarrhea and its discomforts. It's the antidiarrheal that also contains antispasmodic ingredients. Your Robins representative will be around soon with the details. Order heavy and be prepared for big summer sales and profits.

Allbee® with C, All-Season Vitamin, on Deal in 2 Sizes


Leading B-Complex with C Vitamin

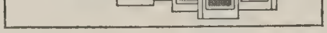
From April 1 - May 31 you can stock up both on Allbee with C 30's and 100's during A. H. Robins' chance of a springtime deal. Your Robins representative has a special offer, but we promised not to steal his thunder, so he'll tell you all about it the next time he comes around. Summer's a good time to sell America's leading B-complex with C Product. And remember, dentists prescribe it more than any other vitamin.

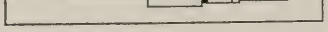
Promote Donnagel as the One for the Road

Homemade Displays Can Increase Summer Sales

Millions of Americans on the move to vacation spots this summer will be wise to take along Donnagel for traveler's diarrhea and its discomforts. But you've got to tell them to sell them. You can make a convincing case for Donnagel by promoting it as an item that's as basic for vacationing as suntan lotion, dark glasses and beach umbrellas.

Whenever you feature vacation and travel items, include Donnagel as an integral part of your display. Ask your Robins representative for a supply of colorful shelf talkers shaped like suitcases. Fit these over or under the plastic Donnagel bottle as a reminder to take Donnagel along just in case.





Homemade displays can also be effective sales aids. All it takes is a few items you have around the store and a little ingenuity. A couple of suggestions: (1) paste a road map of the United States on stiff cardboard and wire some toy cars and airplanes to the surface. Letter on a road sign directing the customer to Donnagel for traveler's diarrhea. Set up your sign next to the Donnagel counter display. (2) using posterboard, cut two slits for a pair of sunglasses, wire on a toothbrush, paste on the sun, letter an appropriate message, and bring out the Donnagel. A. H. Robins is advertising Donnagel heavily to physicians this spring and summer, so be prepared to fill a lot of prescriptions. For extra profits this vacation season, stock, display, recommend, and sell DONNAGEL.

Incidence of Colds, "Flu," & U.R.I. Relatively High During April and May

According to statistics the incidence of colds, influenza, and U.R.I. after dropping in March, tends to level off during April and remain about the same. While not as high as during the winter months, it is about the same as late September. Much of the blame can probably be placed on the fickle spring weather. One day it's warm and dry (almost beach weather), and the next it's snowing and blowing like mid-winter.

You'll still be seeing plenty of customers with spring coughs and colds, so don't put away those Robins cough and cold preps. Keep right on displaying and promoting the complete line of Robitussins and Cough Calmers. And remind your customers that Robitussin-PE® opens clogged noses and clears stuffy sinuses as it relieves coughs.

A. H. Robins Company, Richmond, Va. 23220

The Maryland Pharmacist

NATHAN I. GRUZ, *Editor*

650 WEST LOMBARD STREET
BALTIMORE, MARYLAND 21201

MEMBER STATE PHARMACEUTICAL EDITORIAL ASSOCIATION SPEA

VOLUME 45 APRIL 1969 NUMBER 4

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Editorial . . .

MARYLAND NEW HEALTH LAWS

The 1969 State Legislature passed a number of laws affecting health which will have considerable impact upon pharmacy.

First, a new Department of Health and Mental Hygiene has been created to encompass all activities and agencies within the state that are involved in health. The present Commissioners of Health and Mental Hygiene will be under a cabinet-level Secretary of Health and Mental Hygiene.

Thus, one man will have the authority and responsibility for all matters pertaining to health. The Board of Health and Mental Hygiene is also superseded. Independent boards such as the Board of Pharmacy will be responsible to the Governor, but through the new Secretary of Health and Mental Hygiene.

Second, a Drug Abuse Authority will operate under a "Comprehensive Drug Abuse Control and Rehabilitation Act," to combine and correlate all efforts of federal, state, local communities and private individuals and organizations. Included are the areas of prevention, diagnosis, treatment, rehabilitation and control, as well as education and research and public information.

Pharmacists are key health personnel in making drugs available to patients. They are the compounders, dispensers, custodians and distributors of drugs in health care channels. Pharmacists are the health professionals educated and trained to serve the public's requirements in the area of all drugs—*pharmaceuticals.* Their education and training is directed to assuring the availability of the proper medication wherever and whenever needed.

As a result of these new laws, we look forward to greater utilization of pharmacists in the public health interest in all programs where medical care is involved. Effective health care means effective use of an essential human resource—pharmacists.

For Your Health's Sake

All smokers of cigarettes—especially physicians, pharmacists, nurses, ministers, dentists, teachers, youngsters and their parents—were urged to rethink their attitude towards smoking, Robert E. Farber, M.D., Commissioner of Health, Baltimore City Health Department, noted in one of his weekly letters to Mayor Thomas D'Alesandro of Baltimore City.

Overwhelming Evidence

"There is overwhelming evidence," he said, "that smoking a pack or more a day contributes to a susceptibility to lung cancer, bronchitis, emphysema and other diseases. To our younger generation I say—don't start this vicious habit. To smokers I urge a cessation of the habit with the hope that they will by example discourage others from starting an addiction which becomes less esthetic as time goes by."

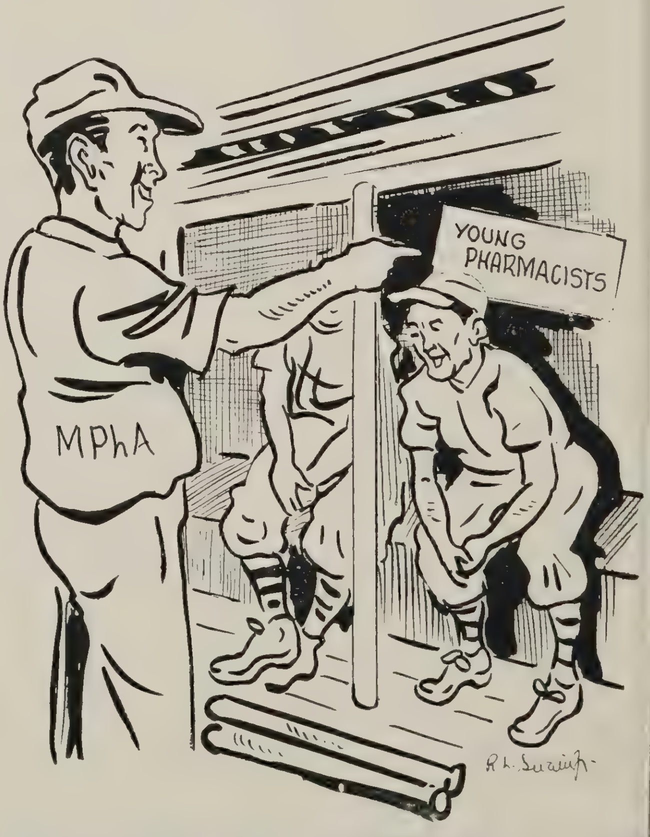
Be Alert To Environment

Dr. Farber asked residents to be alert and sensitive to the relationship of health to physical environment. "There is the necessity for cleanliness and orderliness in our personal living in our homes, our businesses, and in our neighborhoods," he said.

Importance of Education

The younger generation was urged to consider the importance of education. Dr. Farber emphasized that education was the only key to job opportunity and improved living standards. "Do not be turned away from the goals of a good education by more immediate and usually false ideas of security and happiness," he stressed.

"Education leads to broader horizons in living, economic security, and purposeful participation in the struggle for a better existence of all mankind."



"YOUNG PHARMACISTS — ANSWER THE CALL FOR
WINNING TEAM"

Loyalty is a love affair!

Barre
DRUG COMPANY

NATIONAL

In Maryland you are first and foremost in our hearts and mind. Why? Because Barre-National is the last broad-range pharmaceutical manufacturer owned by Marylanders.

We're "home folks" with a great sense of loyalty. And we love to promptly service your needs of OTC SPECIALTIES, TABLETS & CAPSULES, SUPPOSITORIES, WET PACK, DRY PACK, LIQUID PHARMACEUTICALS, OINTMENTS, INJECTABLES, OPHTHALMIC SOLUTIONS. *Give us a try.*

BARRE - NATIONAL DRUG CO., INC.

4128 HAYWARD AVENUE • BALTIMORE, MARYLAND 21215 • PHONE: 542-5272

PHARM-AID
is YOUR OWN CONTROLLED LABEL

YOU can promote, display and sell it with confidence, secure the knowledge, that

YOU are offering a quality product backed by reliable guarantees.

YOU are competitive with even the largest discounter, chain, etc.

YOU are building a brand name that will be available only in independently owned and operated retail drug stores.

No large quantity purchase requirements. PHARM-AID Products are further described and illustrated in the monthly issues of BETTER BUYS which Calvert Drug distributes to its members.

Calvert has an exclusive franchise in this area. Ask your Calvert salesman for details.

CALVERT DRUG COMPANY

901 Curtain Avenue **Baltimore, Md. 21218**

Phone 467-2780

Maryland Board of Pharmacy News . . .

Violations of Advertising Law

TO: ALL PHARMACISTS AND PHARMACIES
LICENSED BY THE MARYLAND BOARD
OF PHARMACY

In recent months a number of advertisements by licensees constituting possible violations of Section 266A(c)(4)(iv) and Section 266A(c)(4)(v) of Article 43 of the Annotated Code of Maryland (1965 Replacement Volume) have been brought to the attention of the Board. The purpose of this letter is to advise all licensees of recent rulings of the Attorney General regarding these two sections of the pharmacy law and to put all licensees on notice with respect to the policy of the Board concerning such advertisements which may appear in the future.

Section 266A(c)(4)(iv), hereafter referred to as "the prescription drug discount advertising prohibition," prohibits:

> "The advertising to the public by any means, in any form or through any media, the prices for prescriptions, dangerous or nonproprietary drugs, or fees for services relating thereto or any reference to the price of said drugs or prescriptions whether specifically or as a percentile of prevailing prices, or by the use of the terms 'cut rate,' 'discount,' 'bargain' or terms of similar connotation."

Section 266A(c)(4)(v), hereafter referred to as "the claim of professional superiority prohibition," prohibits:

> "The advertising or claiming to the public of professional superiority in the compounding or filling of prescriptions or in any manner implying professional superiority which may undermine public confidence in the ability, character and integrity of other pharmacists."

The Board has submitted a number of these advertisements to the Attorney General and has obtained a series of rulings which now establish some clear guidelines as to the type of advertisements which will no longer be permitted by the Board. A summary of these rulings is set forth below:

(a) In a letter dated January 12, 1968, the Attorney General ruled that the Board of Pharmacy has the authority under Section 266A of Article 43 to suspend or revoke the license of a pharmacy as well as that of a pharmacist for violation of the two above quoted provisions.

(b) In a letter dated April 9, 1968, it was ruled that the juxtaposition of the word "discount" and the statement "let us fill your next prescription" in the same advertisement constitutes a violation of the prescription drug discount advertising prohibition. In the same letter he ruled that the juxtaposition of the phrase "don't say drug store . . . say (name of pharmacy) . . . there is a big difference" with the phrase "let us fill your next prescription" implies a superiority of the pharmacy in the compounding of prescriptions and violates the claim of professional superiority prohibition.

(c) In a letter of January 3, 1969, it was ruled that an advertisement containing the phrase "we invite you to compare prices and at (name of pharmacy) you get an extra bonus . . . top value stamps" which further offered a hundred extra trading stamps with any purchase of $5.00 excluding purchases of cigarettes and food related items used in conjunction with the statement "let our pharmacy fill your next prescription while you shop" created an inference that trading stamps were offered with prescription purchases and that such an offer was a violation of the prescription drug discount advertising prohibition.

(d) In a letter dated January 17, 1969, the Attorney General ruled that an advertisement distributed to physicians only captioned "examples—(name of pharmacy's) *low* prescription prices confidential list for physicians' reference only" which listed the names of prescription drugs with prices for designated quantities beside each name violated the prescription drug discount advertising prohibition in that such a list circulated to physicians only was still an advertisement made "to the public" within the meaning of Section 266A(c) (4) (iv).

(e) In a letter dated April 2, 1969, it was ruled that exterior signs appearing on a pharmacy which contained in bold print the name of the pharmacy, the outline of a mortar and pestle and the phrase "Discounts 15% to 50%" violated the prescription drug discount advertising prohibition.

(f) In a letter dated April 9, 1969, the Attorney General ruled that an ad appearing in a general circulation newspaper, directed to all doctors in the area but which offered a 30-day free supply of any prescription constituted a violation of the prescription drug discount advertising prohibition. In the same opinion it was ruled that an ad containing specific statements that all pharmacists in the pharmacy were State licensed professionals who did no serve as clerks or department managers and specialized no only in serving the patient but also in keeping abreast o modern medicine, methods, and products constituted a violation of the claim of professional superiority prohibition

Henceforth the Board intends to follow a rigorous enforcement policy with respect to the prescription drug discount advertising prohibition and the claim of professiona superiority prohibition. Any licensee who is responsible fo the publishing or the utilizing of an advertisement violativ of these sections as they have been construed by the A torney General will be summoned for a hearing before th Board and, if found guilty, will be subject to appropria administrative action.

Tofrānil®
brand of
imipramine
hydrochloride
Geigy
Drugs such as this don't come along every day
—but don't tell our research people, because they spend every day searching for them.
Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

Photograph by Harold M. Lambert

This man is a professional

He's a professional bowler. He knows there is more to bowling than strikes. Your Youngs Drug Products salesman is a professional, too. He knows there is more to selling than taking orders. That something "more" is training and experience.

Your Youngs salesman understands the drug business. He knows merchandising, sales promo tion, stock control, and many things to help your business... because he only calls on drug stores.

So next time the Youngs man is in your store, remember, he's there to offer you his full service. Ask him about our full line of products like Bidette, Atha-Spray, Atha-Powder, Wash-Up, Youngs Nail Polish Remover Pads, Trojans brand prophylactics...and our latest profit maker, Young People, the modern convenient aid in acne therapy. Our men at Youngs are more than Trojan salesmen...much more.

TM
Youngs Drug Products Corporation.
865 Centennial Avenue, Piscataway, N. J. 08854.

SKF Drug Identification Code

Smith Kline & French Laboratories has adopted a new system of numbering its drug product packages and is beginning to imprint the new product numbers on all labels and shipping cases. Starting next fall, product identification codes will be imprinted on individual tablets and capsules.

Donald van Roden, Vice President and General Manager—Pharmaceuticals, said that the changes represent a corporate effort to "help show the way toward more positive, definitive product identification." SK&F is making the changes, he added, "not because we have to, but because we ought to."

Every SK&F drug product has been assigned a new identification number consisting of five characters. The first three characters—an alphabetic letter and two digits—represent product, form and strength. The last two characters—both digits—represent package size.

By January 1970, the three-characters — both digits — represent package size.

By January 1970, the three-character code representing product, form and strength will be imprinted on every tablet and capsule coming off the SK&F finishing line.

SK&F's new product numbers conform to the National Drug Code developed recently by representatives of the drug industry in cooperation with the Food and Drug Administration. This uniform Code, which most pharmaceutical manufacturers have agreed to adopt, employs a maximum of nine characters to identify product, form, strength, package size and manufacturer.

When fully adopted, the Code is expected to simplify product identification and facilitate reimbursement to pharmacists for prescriptions filled under third-party drug payment programs. It also is expected to serve as an aid in product recalls, a deterrent to substitution, and a billing and inventory control device for drug distributors.

SK&F's identification number as a participant in the National Drug Code is seven (7). This number, along with the initials NDC (for National Drug Code), will appear as a prefix before the product number on every SK&F package label.

EXAMPLE:

Product	*Form & Strength*	*Size*	*Code Appearing on Package Label*
'Compazine'	Tablets, 5mg.	100's	NDC 7 C66 20

It is anticipated that pharmacists seeking third-party reimbursement for SK&F prescriptions will be asked to enter both the NDC 7 prefix and the appropriate product number on their reimbursement forms.

The salesmen who collect the most commissions are those who make at least seven calls on a prospect before giving up. According to sales expert Howard Garroway, 80% of all sales are made after the fifth call. However, 43% of all salesmen make one call and quit; 25% call twice and then stop; 12% give up after the third call. In other words, the 80% of all sales referred to are made by only 20% of the salesmen—those who kept on calling after the others gave up.

Obituaries

LEON GREENBERG

Leon Greenberg, 40, died April 27, 1969, at Baltimore County General Hospital from injuries received in a auto accident.

A native Baltimorean, Mr. Greenberg was a graduate of City College. In 1949, he received his B.S. from the University of Maryland School of Pharmacy. For the next seven years, he worked as a pharmacist in several Read drug stores.

He and his brother, Morton, opened a drugstore in Severna Park in 1949. Six years later, the brothers opened a second drugstore in Glen Burnie. Both stores are known as Lee's Pharmacy.

He was a member of the Maryland Pharmaceutical Association, B.M.P.A., Alpha Zeta Omega Fraternity.

Mr. Greenberg belonged to the Baltimore Hebrew Congregation.

Survivors are his wife, the former Anita Berman; a son, Barry Greenberg, both of Pikesville; his father, Isadore Greenberg, of Baltimore, and two brothers, Joseph and Morton Greenberg both of Pikesville.

WINFIELD A. WALB SR.

Winfield A. Walb, Sr., 55, died April 28, 1969, after a lengthy illness.

A native Baltimorean, he was a 1933 graduate of City College and a 1937 graduate of the University of Maryland's School of Pharmacy.

His father, W. Scott Walb, opened the pharmacy known as W. Scott Walb and Son Pharmacy, in 1929. When his father retired in 1948, he took over the management of the pharmacy.

He was a member of the Maryland Pharmaceutical Association, Baltimore Metropolitan Pharmaceutical Association and the National Association of Retail Druggists.

A Mason, he belonged to Highland Lodge, No. 184. His hobby was collecting first day covers and entire pages of issues of United States stamps. He also directed a jazz band during his college days.

Survivors, besides his father, are his wife, the former Dorothy Kossman; a daughter, Miss Bonnie Buchanan Walb; a son, W. Alexander Walb, Jr., and a sister, Mrs. Nellie Robinson, all of Baltimore.

Every day is the best day in the year. He is rich who owns the day, and no one owns the day who allows it to be invaded with fret and anxiety. Finish every day and be done with it. You have done what you could. Forget blunders and absurdities as soon as you can. Tomorrow is a new day—too dear, with its hopes and invitations, to waste a moment on the yesterdays.

—*Ralph Waldo Emerson*

How does Roche® keep in touch with grass roots pharmacy problem

The Roche community pharmacy panel

That's how! What's more logical than sitting down with small groups of pharmacists around the country to learn their problems and help find the answers?

At these daylong conferences sponsored by Roche, attention is given to all problems, large or small, that concern the pharmacist as a professional and as a community member.

General problems of pharmacy management, doctor-pharmacist and pharmacist-patient relationships and Roche policies are discussed.

Other topics may include the expansion or improvement of services to nursing homes, small hospitals, community pharmacies and civic health organizations.

But that's only the beginning.

Administrative pharmacists, working for Roche, take it from there. These practical professionals make recommendations to Roche management and help create and implement programs—based on your needs and suggestions. This is the way our return-goods policy, nursing home program, product data services, and many other programs originated. And this is the way future pharmacy programs will be devised.

Community Pharmacy Panels help Roche keep its feet deep in the grass roots of this important profession.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

a brass tacks program t

Medicare spells unprecedented opportunity . . . for the many millions who will be enjoying its benefits . . . and for the pharmacies prepared to serve them best. Gilpin's continuing program of maximum service now includes a complete pharmacy-oriented Medicare convalescent aids program.

Based on these down-to-earth considerations, it's a brass tacks program to make your pharmacy the prime source in your area for all convalescent aid products: You are the most logical source for such purchases and rentals. You know the physicians and the families, you provide their other health needs, you are the most convenient, reliable source. And Medicare will soon
greatly expand purchases and rentals of con
cent aids . . . to a third of a billion dollars in

Gilpin provides you with these imp
requisites: 1. A minimum essential inventory
bined with prompt catalog sale delivery.
complete profit-making package . . . promo
literature, display equipment, professional
sel . . . and a 40% plus mark-up.

Gilpin-serviced pharmacies also
these vital customer delivering services . .

¶ New grow-power through the e
new Community Shield Pharmacy and
traffic building programs.

S/

liver medicare customers

¶ The greater accuracy and efficiency
fully computerized UNIVAC and IBM con-
ed inventory and billing system. And now,
computerization makes possible the regular
nce of individual monthly reports of DACA
s, quantities and dates on which they were
lied.

¶ A comprehensive store planning and
delling service which includes specialized
in site selection, floor design, fixture plan-
installation, financing and merchandising.

¶ A wide range of personalized profes-
l services in every Gilpin house . . .
well-trained pharmacy oriented sales force

- a financial service consultant
- a fully stocked pharmaceutical library
- the services of a pharmaceutical consultant

Depend on Gilpin for what it takes to help your pharmacy serve more effectively.

THE HENRY B.
GILPIN
COMPANY
BALTIMORE • DOVER • NORFOLK • WASHINGTON

. . THE SYMBOL OF SERVICE TO PHARMACY

Ninth Annual Robert L. Swain Pharmacy Seminar

The Ninth Annual Robert L. Swain Pharmacy Seminar was held on March 20, 1969 at the Holiday Inn Downtown in Baltimore. The Seminar was co-sponsored by the Maryland Pharmaceutical Association and the University of Maryland School of Pharmacy. The subject was "The Pharmacist's Responsibility In Ophthalmology."

Paul Freiman, Swain Seminar and Continuing Education Chairman, presided at the afternoon session and Mrs. June Shaw presided at the evening dinner session. This format was an innovation and was followed by workshops and displays of Ophthalmic drug products under the direction of Dr. Peter P. Lamy, Associate Professor of Pharmacy and Alan J. Jaskulski, Graduate Student.

Manufacturers participating with displays were: Abbott Laboratories, Barnes-Hind, Millipore Corporation, Smith, Miller and Patch, Tilden-Yates (Crooks-Barnes) and White Laboratories.

The 1969 Swain Seminar Committee consisted of: Paul Freiman, Chairman; Dr. William J. Kinnard, Jr., Co-Chairman; Harry Bass, Irving I. Cohen, Dr. Peter P. Lamy, James Mitchell, Chester L. Price, Henry G. Seidman, June Shaw, Dr. Ralph F. Shangraw, H. Nelson Warfield and Nathan I. Gruz, Secretary.

"THE PHARMACISTS RESPONSIBILITY IN OPHTHALMOLOGY"

Afternoon Session—Paul Freiman, Presiding

THE CHEMISTRY OF NATURAL PRODUCTS USED IN OPHTHALMIC PREPARATIONS
Dr. Ralph N. Blomster, Professor & Head, Department of Pharmacognosy

OPHTHALMIC PHYSIOLOGY AND PHARMACOLOGY
Dr. William J. Kinnard, Jr., Dean, School of Pharmacy

CONTACT LENSES AND CONTACT LENS SOLUTIONS
Dr. Peter P. Lamy, Associate Professor of Pharmacy

THE PHARMACEUTICS OF OPHTHALMIC SOLUTIONS
Dr. Ralph F. Shangraw, Associate Professor and Acting Head, Department of Pharmacy

Panel Discussion

Evening Session—Mrs. June Shaw, Presiding

DINNER SPEAKER—Samuel L. Fox, M.D.
"OCULAR THERAPY — Then and Now"

EVENING—Workshops and Displays at the University of Maryland School of Pharmacy
Dr. Peter P. Lamy — Alan J. Jaskulski

The text of Seminar presentations will be published in subsequent issues of *The Maryland Pharmacist.*

Workshops at Swain Pharmacy Seminar. Dr. Peter P. Lamy, Associate Professor of Pharmacy, shown right in second photo from top, was in charge.
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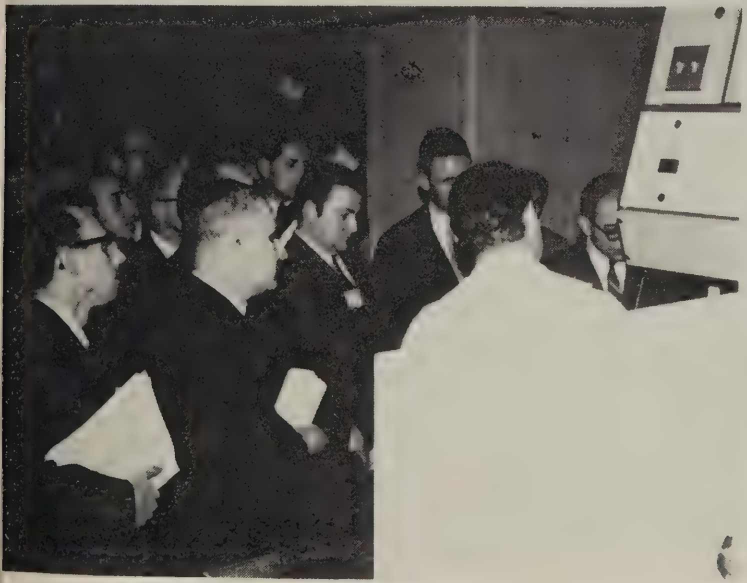

Photo, top row, left.
Front row (left to right)—Paul Freiman, Seminar Chairman; Dean William J. Kinnard, Jr., Co-Chairman; Executive Secretary Nathan I. Gruz, Back row (left to right—Seminar speakers Dr. Peter P. Lamy, Dr. Ralph F. Shangraw, and Dr. Ralph N. Blomster.

Top Row, right—Exhibit of Opthalmic Products

Middle row (left) Dr. Samuel Fox, lecturer; center, Workshop in Swain Model Pharmacy; right, June Shaw, Chairman, evening session.

Bottom row—Workshop in laminar flow (left) and exhibits of products.

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Deodorant or Anti-Perspirant

With the multitude of deodorants and anti-perspirants we have on our shelves these days, customers can easily be undecided about what they want.

Perhaps if we understand the nature of perspiration, we will be able to help our customers make a decision more easily. Perspiration comes from two sets of glands: eccrine and apocrine.

The eccrine glands are widely distributed over the body and are the "regulators" of body heat. Perspiration from these glands seldom causes an odor problem. Eccrine perspiration is present in people of all ages.

Sweat from the apocrine glands does not start developing until teenage and tapers off in elderly people. Apocrine glands are found in the underarm region and seem to be triggered by emotional tension, stress, etc. This is the reason why children and older people seldom have an odor problem.

Deodorants for the underarm area are formulated to mask odor, not to stop perspiration. (Beware of some deodorants which have no deodorizing ingredient but depend on perfume to mask odor. These products are worse than no deodorant at all.)

Anti-perspirants are formulated to stop perspiration and retard bacterial growth. Dermatologists recommend the use of anti-perspirants only in the underarm area. They say it will do no harm to stop perspiration in a small area like that.

Since anti-perspirants affect body function, they are considered drugs by the Federal Food and Drug Administration and *must* have the active ingredients listed on the label.

Most of the anti-perspirants contain one or more of the aluminum salts (aluminum chloride, aluminum sulfate, aluminum chlorhydroxide complex, etc.). The results obtained from these salts vary with different people. If a customer says his or her deodorant isn't working, perhaps switching to another one that contains a different aluminum salt will do the job.

Many people cannot apply an anti-perspirant immediately after shaving without causing a rash. Shaving the underarm area at night and applying the anti-perspirant in the morning sometimes solves that problem.

According to an article in *Today's Health* published by the American Medical Association, the type of product—cream, liquid, roll-on, spray—does not alter the efficacy of the product. But when your customer says she is sure that a cream deodorant which can be rubbed in is more effective, don't try to switch her to a spray. She probably will never believe it's going to work.

In other words, the choice of type of product is entirely personal, and all will work equally well.

And don't forget that for the person who develops an allergic reaction to a deodorant, you have excellent products in your hypo-allergenic lines which should solve her problem.

Madame Helene Rochas

One of the most fascinating women in the cosmetic-fragrance world today is Madame Helene Rochas, internationally known for her beauty and consistently chosen as one of the world's best dressed women. Her personality, strong but flexible, has made the Marcel Rochas company one of the three top names in the French industry.

Marcel Rochas was a designer who built a tradition of "great elegance" for the clothes he designed. In 1945 he introduced a fragrance, "Femme", not for all women, but definitely in the "elegant" tradition for those who could wear it. In 1949, he introduced "Moustache" for men. The dinner at which it was introduced was held in a salon where the walls were hung with a number of famous paintings featuring, of course, moustaches!

Marcel Rochas died of a heart attack in 1955. Madame Helene took over and has done a superb job since that time. She is a slim woman with great beauty and a spontaneous smile, a picture of feminine sophistication, but she has conquered a tough, competitive business.

Madame Rochas made a trip to the United States, and after her visit here, was asked what she thought about the attitude of American women to perfume. She said, "American women don't wear enough perfume. For French women, perfume is a permanent need. Perfume is one of the oldest, most secret and dangerous feminine weapons." She added that a woman shouldn't change her perfume too often; her husband would get dizzy.

Madame Rochas said her own personal trick was to spray perfume on the clothes in the closet and then close the door. "The perfume then becomes an aura which doesn't impose on anyone's taste."

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M.Ph.A. Spring Regional Meeting

The Spring Regional Meeting was held at the Chestnut Ridge Country Club, April 17, 1969. Samuel Wertheimer, President, presided. The Executive Committee convened at 10:00 a.m. with the general meeting following lunch. Executive Secretary, Nathan I. Gruz, presented a report on the status of the Medicaid Program and issues before the forthcoming Annual Meeting of the American Pharmaceutical Association.

The fourth year class of the University of Maryland School of Pharmacy under faculty adviser Dr. Benjamin Allen, Associate Professor of Pharmacy, were luncheon and meeting guests of the MPhA. The officers and members of the Executive Committee sponsored the luncheon for the students.

Vice President Jerome Mask was moderator for the panel presentation on "The Role of Supportive Personnel in Pharmacy." The panelists were Russell A. Benedict, Executive Secretary, American College of Apothecaries and Henry J. Derewicz, Director of Pharmacy Service, Johns Hopkins Hospital. Their addresses will be published in subsequent issues.

Clinton Englander Receives Bowl of Hygeia Award

Oakland pharmacist Clinton W. Englander was honored by the Maryland Pharmaceutical Association as its 1969 recipient of the A. H. Robins "Bowl of Hygeia" Award for outstanding community service.

Mr. Englander, owner of Englander's Pharmacy at 205 East Alder Street, received the award April 17 during the Association's Spring Regional Meeting at Chestnut Ridge Country Club in Baltimore.

Making the presentation was James E. Teabo, medical service representative in the Chesapeake Division of A. H. Robins Company. Participating in the ceremony was Samuel Wertheimer of Cumberland, president of the Maryland Pharmaceutical Association.

The recipient is a native of East Cleveland, Ohio, and a 1940 graduate of the Wayne State University College of Pharmacy.

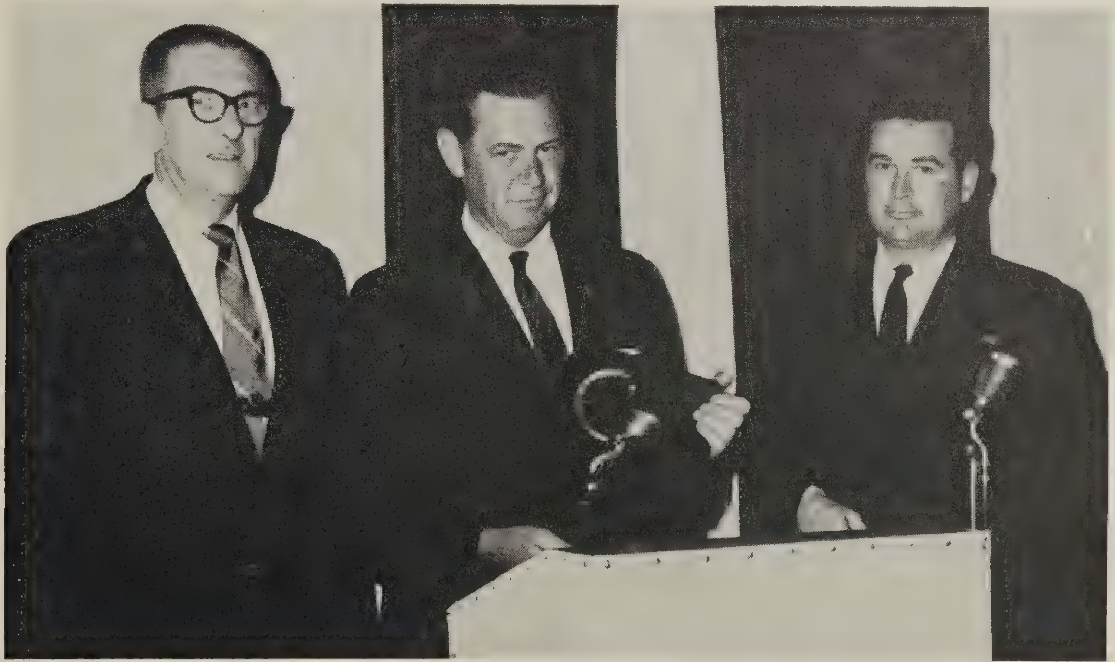
Mr. Englander is president of the board of the Garrett County Community College, vice president of the Garrett County Board of Education, and a past president of the Garrett County Council of Parent-Teacher Associations.

In the past he has served on the boards of the Maryland Congress of Parents and Teachers, the Shawnee Council of the Girl Scouts of America, the Garrett-Allegany Heart Association, the Mt. Top Chamber of Commerce and the Deep Creek Lake Promotional Council. He is a member of St. Matthews Episcopal Church, which he is presently serving as a senior warden.

Mr. Englander is a member of the Maryland and American Pharmaceutical Associations, as well as the Allegany-Garrett Pharmaceutical Association.

The "Bowl of Hygeia" Award, presented annually through the Maryland Pharmaceutical Association, is a handsome mahogany plaque measuring 10 by 13 inches and featuring the Bowl of Hygeia cast in bronze.

It is awarded in appreciation of the time and personal sacrifice devoted by pharmacists to the welfare of their respective communities.



Clinton W. Englander of Oakland, center, receives the 1969 Bowl of Hygeia Award at the M.Ph.A. Spring Regional Meeting. President Samuel Wertheimer of Cumberland is on left and James Teabo of A. H. Robins Co. is on right.

BMPA *Officers Confer With The Mayor*

Officers of the Baltimore Metropolitan Pharmaceutical Association met with Mayor Thomas J. D'Alesandro, III to discuss health services for the indigent in Baltimore City. At the meeting were: President Bernard B. Lachman, President-elect Anthony G. Padussis and Executive Director, Nathan I. Gruz.

Mr. Gruz recommended to the Mayor the establishment of an Office of Health Service Planning for maximum utilization of all available and potential health resources. The Office of Health Service Planning would be attached directly to the Mayor's Office, separate from the Baltimore City Health Department which would concentrate on the traditional preventive and educational health programs under City Health Commissioner Dr. Robert Farber.

Mr. Gruz offered the cooperation of the City's pharmacies to serve as community information centers for various city agencies, such as Health, Sanitation, Education, Welfare, Fire, Police, Traffic and Transit, Housing and Urban Affairs and Community Relations.

President Lachman requested that security measures be intensified for the pharmacies in the City to enable them to provide pharmacy service to people throughout the City.

Mayor D'Alesandro was presented a Distinguished Service Award for "Devotion to Civic and Community Service" by the Maryland Pharmaceutical Association at the 1969 Annual Installation and Banquet of the Baltimore Metropolitan Pharmaceutical Association in January.

Courtesy Paramount Photo Service

Mayor Thomas J. D'Alesandro, III, of Batlimore, second from right; Bernard B. Lachman, President Baltimore Metropolitan Pharmaceutical Association, on right with Secretary Nathan I. Gruz, left and Anthony G. Padussis, President-Elect.

A Preview of Community Pharmacy–1968

The preliminary LILLY DIGEST report of 1,135 community pharmacy operations reveals several interesting developments. When the individual income and expense statement items are expressed as a percent of total sales and compared to 1967 LILLY DIGEST data, they indicate:

> Cost of goods sold remained unchanged as did gross margin for the third year; but total expenses increased significantly for the fourth consecutive year resulting in a lower net profit during 1968.

Total sales reached a record high of $200,977, the first time average LILLY DIGEST sales have exceeded $200,000, reflecting an increase of $12,548 (6.7 percent). This total dollar gain was due to a substantial upswing in prescription revenue of 10.4 percent and an increase in other sales of 4.0 percent. During 1968, prescription sales as a percent of total sales increased to 43.3 percent (up from 41.8 percent in 1967). This continues an uninterrupted 25-year uptrend in prescription revenue as a percent of total sales.

The number of prescriptions dispensed during the year rose to 23,483; a substantial increase of 1,939 prescriptions. Of this total, 45.0 percent were new prescriptions. This continues a long-term trend in which refills have annually increased as a percentage of the total prescription volume. Refills provided 55.0 percent of the total prescription activity. The average prescription charge increased four cents during 1968, from $3.66 to $3.70.

Total operating expenses increased by 8.3 percent and averaged 31.6 percent of total sales. Net profits decreased to 4.3 percent in the face of escalating expenses — notably employee wages. Rent expense rose to 2.6 percent of sales, up from 2.5 percent recorded in each of the past five years. Total income (salary plus net profit, before taxes) established a new high of $24,548 per pharmacy-owner, but decreased to 12.2 percent of total sales.

Inventory levels increased in dollars but remained relatively constant as a percent of sales at 17.9 percent. The sales productivity of the prescription department inventory reached an all-time high of $7.42 per stock dollar while other merchandise again declined to a record low of $4.69.

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INSTALLATION DINNER DANCE

The Prince Georges-Montgomery County Pharmaceutical Association held its 15th Annual Installation Dinner Dance on April 26, 1969 at the Burn Brae Dinner Theatre Club on Columbia Pike, Burtonsville. For the first time a musical show—"Damn Yankees"—was part of the evening's entertainment.

Highlight of this year's event was the attendance of Willard B. Simmons, Executive Secretary, National Association of Retail Druggists. Mr. Simmons spoke of NARD's current and future programs, as well as their policies on national issues.

Installed as President was Paul Reznek, long time secretary of the group and editor of its "Bi-County Pharmacist." He served as Assistant to the Executive Secretary of the Maryland Pharmaceutical Association from January 1968 to February 1969.

Mr. Reznek, a 1929 graduate of Temple University, School of Pharmacy, operated the Beltsville Pharmacy, Beltsville, Maryland for over 19 years. He is a member and a regional director of the Metropolitan Pharmaceutical Secretaries Association and a member of the Maryland Pharmaceutical Association, National Association of Retail Druggists and the Alpha Zeta Omega Pharmaceutical Fraternity. He was active for many years in the D.C. Branch of the American Pharmaceutical Association.

He is past president of the District of Columbia Pharmaceutical Association.

Rudolph F. Winternitz was Program Chairman and coordinator of the affair. Samuel Morris was Public Relations Chairman.

Presentations were made by: Jack D. Levy, Manager, Washington Division, H. B. Gilpin Company; Herman Lichterman, Sales Manager, District Wholesale Drug Corporation; and Albert J. Obert, President, Washington Wholesale Drug Exchange.

PAUL REZNEK, President

N. W. Chandler of Landover Hills, outgoing Honorary President receiving citation from Past President Harold M. Goldfeder.

Willard B. Simmonds, Executive Secretary N.A.R.D. was awarded plaque signifying Honorary Life Membership in the Prince George Montgomery County Pharmaceutical Association by Past Preside Harold M. Goldfeder.

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Left to right: Ervin M. Koch, Chairman, Executive Committee; Edward D. Nussbaum, Treasurer; Leonard E. Sogoloff, 4th Vice President; Harold M. Goldfeder, Founding President; Rudolph F. Winternitz, 1st Vice President; Willard B. Simmons, Executive Secretary N.A.R.D.; Paul Reznek, President; Morton J. Schnaper, Honorary President; Martin Hauer, 2nd Vice President; Louis N. Nobel, 3rd Vice President; Gerald Y. Dechter, Paul Bergeron and Richard D. Bayliss, Executive Committee. Dominic J. Vicino, Secretary, is not in photograph.

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Pharmacy's Agenda—Priorities for 1969

- –Organized Health Programs
- –Prescription Pre-payment Plans
- –Intra-Professional Relations
- –Pharmacy Education–Curricula and Continuing Programs
- –Drugs: Use, Misuse, Abuse and Pharmacists' Responsibilities

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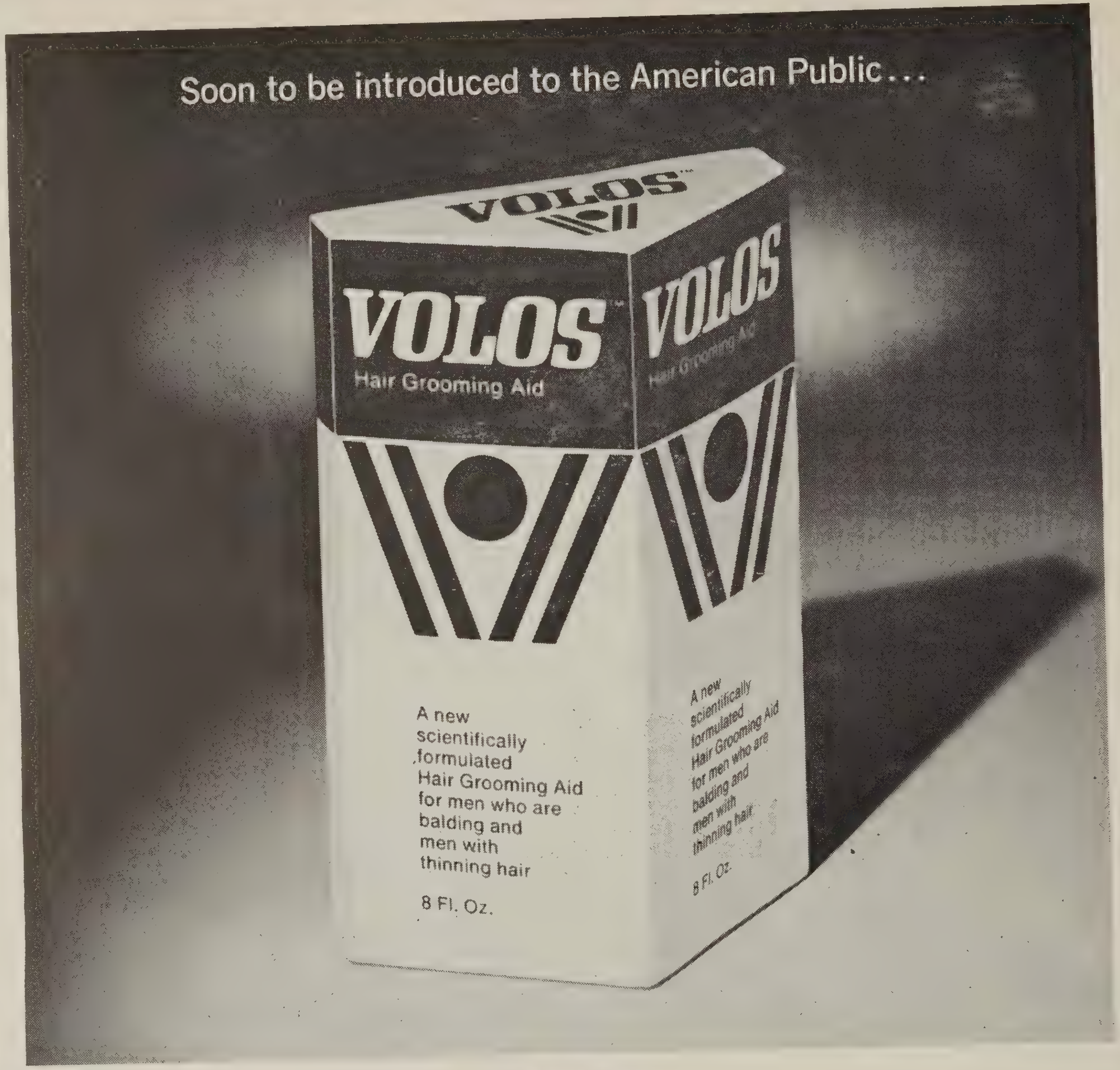
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Editorial . . .

Pharmacy's Agenda 1969

As we look upon pharmacy U.S.A. in mid-1969, we are at no loss to list problems which are seemingly insoluable. A thick catalogue of priority matters could be drawn up.

It is incumbent upon the leadership of pharmacy nationally and upon us in Maryland to select and concentrate upon some of these items. Here are a few:

1. *Organized Health Programs*

   The requirements for more effective use of health manpower and resources to bring good health care to all people will produce more governmental, non-governmental and joint programs.

   Pharmacy must clearly demonstrate by the actions of its practitioners that their functions as health professionals always come first.

   Do all pharmacists and all pharmacies contribute to a public and governmental recognition of such a commitment within our own ranks?

2. *Pharmaceutical Socio-Economics*

   Prescription pre-payment (third-party) plans are expanding. A form of universal health insurance is a goal accepted by a large cross-section of our society—including many in government, labor, medicine, education and the general population.

   The delivery of pharmaceutical services will have to become as efficient and economical as possible. Automation, sophisticated electronic data-processing techniques and supportive personnel will be utilized extensively in both community and institutional pharmacies.

3. *Intra-professional Relations*

   With more than half of the pharmacists in the non-proprietor category, relations between employers and staff pharmacists must become a matter of Association concern.

   Staff pharmacists, and young pharmacists in general, must be brought into more positions of leadership in pharmacy affairs.

   A program directed to integrating recent graduates and the entire younger generation of pharmacists must be developed and implemented. We hope that some initiative will come from these young people themselves as well as from the "old guard."

4. *Education*

   Pharmaceutical education must undergo an ongoing evaluation to determine relevancy to what the profession must know and perform. Professional educational years must prepare for pharmacy in 1970, in 1980 and hopefully for 1990.

   Continuing education opportunities must be expanded by the School of Pharmacy. Recognition and status must be conferred on those who maintain certain standards.

5. *Drugs: Use, Misuse, Abuse and Pharmacists' Responsibilities*

   The "drug society" we live in requires an expert in assuring that all drugs—prescription and non-prescription—are appropriately used. There is a person known as a *pharmacist* who has the education that is designed to provide the knowledge and training to discharge this responsibility.

   As we have indicated above, the education of the pharmacist must be relevant to the roles incumbent upon him to assume.

   Full responsibility for the distribution of drugs must be the pharmacist's. Maintenance of patient drug profiles and reference materials, guidance to the public and consultation to the medical team must be an integral part of pharmacy practice.

   The pharmacist must be a leader in education and information to bring about the proper use of drugs, to prevent the misuse of drugs and to curb abuse. Naturally, the pharmacist both in his attitude and his practice must take positive steps t help his community in eliminating drugs as means of escaping reality.

The agenda above—although incomplete—is a crucia one for pharmacy today and for the future.

Resources for programs and staff must be expanded i we are to meet these challenges. And more pharmacist must participate voluntarily and be prepared to sacrific time and effort if pharmacy is to go forward as a profe sion essential to health care.

Obituary

OSCAR A. POTASH

Oscar A. Potash, 57, a Silver Spring pharmacist a brother-in-law of Governor Mandel died on April 2, after long illness.

He operated a pharmacy in Silver Spring for ma years prior to his illness. He was a 1932 graduate of t University of Maryland School of Pharmacy.

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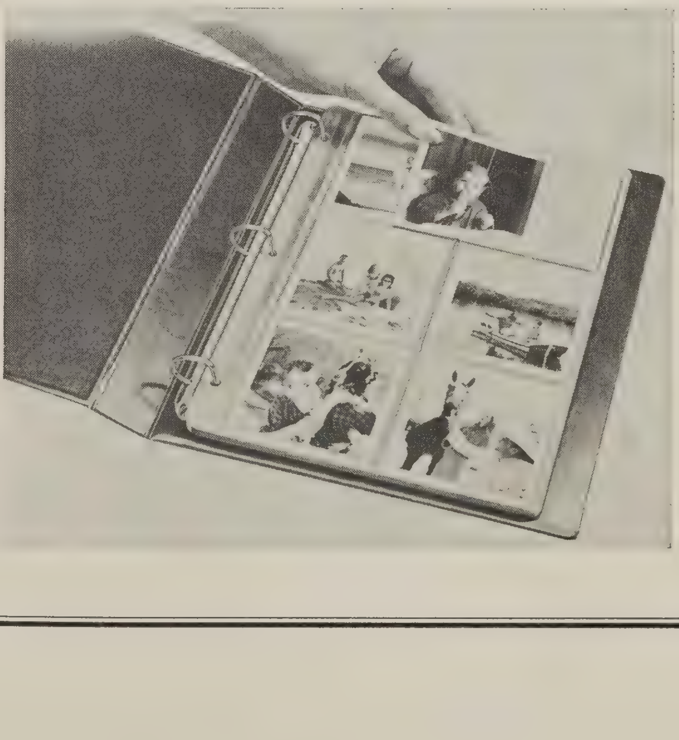


President's Message . . .

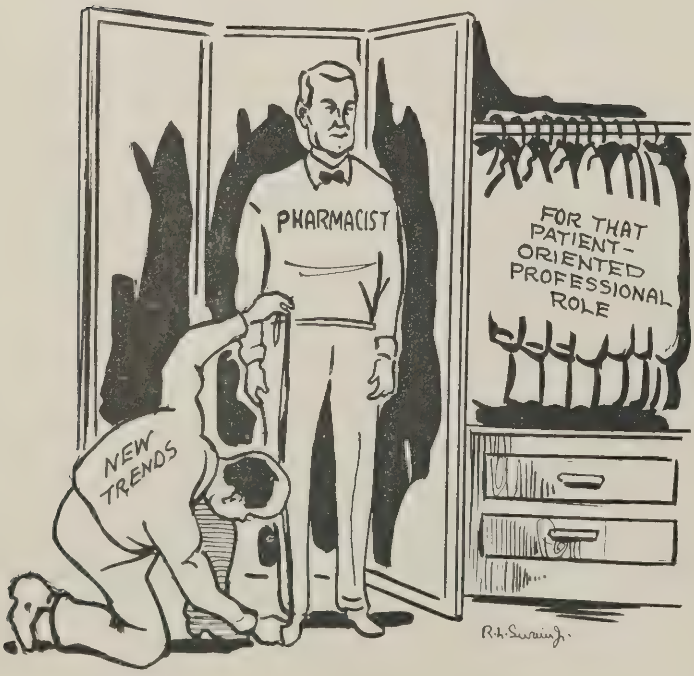
The office of the Maryland Pharmaceutical Association receives more mail regarding the Medicaid Program than any other subject. They concern the chaotic administration of the program resulting in long delays in payment, many incomplete payments for prescriptions sent in and inadequate compensation for services provided.

Our officers and Executive Committee and the Health and Welfare Committee, as well as your Executive Secretary devote more time to these matters than to any other. As a result we have been able to arrange for payment of all outstanding invoices. In addition, Governor Mandel has directed that the $1.50 fee be restored in the Medicaid Program. However, he has insisted that all requests for OTC drugs with or without directions—will be paid for as O-T-C items with a markup, not a fee.

We will continue our efforts to rectify this issue so that *all* prescriptions—whether for legend drugs or OTC's will be compensated for as prescriptions.

As my term in office approaches its end, I look forward to greeting many of the members, TAMPA and LAMPA at our forthcoming Convention. An excellent program has been arranged under the Chairmanship of Earl Kerpelman. I hope to see a great turnout.

SAMUEL WERTHEIMER


PHARMACIST
FOR THAT PATIENT-ORIENTED PROFESSIONAL ROLE
NEW TRENDS

Measuring Up to the New Style

Maryland Board of Pharmacy News . . .

Pharmacy Changes

Pharmacy Changes for the month of March:

New Pharmacies

Drug Fair No. 124, Milton L. Elsberg, President, Rt. 22—Aberdeen Shopping Center, Aberdeen, Maryland 21001.

Garwyn Pharmacy, Richard A. Butler, 2300 Garrison Boulevard, Baltimore, Maryland 21216.

Change of Ownership, Address, Etc.

Fairway Pharmacy, Albert Bank, President, 531 Dale Drive, Silver Spring, Maryland (Formerly owned by Walter Meyer, President).

Dickman's Professional Pharmacy, Arnold Dickman, 7112 Darlington Drive, Baltimore, Maryland 21234 (Formerly Harford Park Pharmacy, Nicholas and Mary Mangione).

No Longer Operating as Pharmacies

Patrick's Pharmacy, David Yevzeroff, President, 562 Kenilworth Avenue, Riverdale, Maryland 20840.

Shure's Drug Stores, Bernard Shure, President, 100 Taylor Avenue, Baltimore, Maryland 21204.

Shure's Drug Stores, Bernard Shure, President, 170 Joan Avenue, Towson, Maryland 21204.

Pharmacy Changes for the month of April:

New Pharmacies

Donnybrook Pharmacy, 246 East Burke Avenue, Towson, Maryland 21204, Maurice Karpa, Owner.

Drug Fair No. 123, 6247 Kenwood Avenue, Baltimor Md. 21237, Milton Elsberg, President.

Change of Ownership, Address Etc.

Chelsea Pharmacy, Inc., 3801 Woodhaven Ave., Baltimore, Md. 21216, Henry Harris, President (Formerly Ben jamin Yevzeroff, President).

Welsh Pharmacy, 22nd and Philadelphia Avenu Ocean City Md., 21842, C. Robert Welsh (formerly locate at 28th and Philadelphia Avenue).

No Longer Operating As Pharmacies

Drug Fair No. 704, Village Green, Crofton, Md. 2111 Milton L. Elsberg, President.

Allen's Pharmacy, 243 Virginia Avenue, Cumberlan Maryland 21502, C. Murray Allen, Owner.

Boenning's Pharmacy, 637 S. Hanover Street, Balt more, Md. 21230, Sidney Smulovitz, Owner.

Bixler & Guild Drug Co., Inc., 44-46 W. Main Stree Westminster, Md. 21157, Cecil E. Guild, President.

Arbutus Pharmacy, 5305 East Driver, Baltimore, M 21227, D. Mendelsohn and M. Getka, Owners.

Pharmacy Changes for the month of May:

New Pharmacies

Boenning's Pharmacy, Sidney Smulovitz, Owner, 14 E. Fort Avenue, Baltimore, Maryland 21230.

Dear Park Pharmacy, D. Healy, B. Bourne, E. Ko owners, 13 East Dear Park Drive Gaithersburg, Maryla 20760.

Poolesville Drugs, B. P. Bourne, Owner, 17617 W lard Road, Poolesville, Maryland 20837.

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July 14, 15, 16, 17, 1969

Registration in the Administration Building beginning Sunday, July 13—2:00 p.m.

SUNDAY, JULY 13

3:00 P.M. Hospitality Room — refreshments for early arrivals

9:30 P.M. Presidential Reception — Courtesy Young Drug Products Corp.—Sunset Room

Dancing and entertainment a la Tamiment

MONDAY, JULY 14

9:00 A.M. Registration Desk Opens

2:00 P.M. FIRST SESSION—Constellation Room

2:00 P.M. Convention Call to Order—President Samuel Wertheimer

Invocation

Opening Remarks—President Wertheimer

Communications

"NARD — Organized for Independent Pharmacy"—Nick Avellone, Chairman of the Executive Committee, NARD

Committee Reports

Treasurer's Report

Report of the School of Pharmacy, University of Maryland, Dr. William J. Kinnard, Jr., Dean

Report of the Board of Pharmacy, Francis S. Balassone, Secretary, Maryland Board of Pharmacy

Announcements

Attendance Prizes

Adjournment

Entertainment Features:

9:00 A.M. Golf Tournament begins

3:00 P.M. Ladies Golf Putting Tournament. Prizes

9:30 P.M. Entertainment—Game Night—Audience Participation—Prizes—Dancing—Ballroom

TUESDAY, JULY 15—SECOND SESSION—
Constellation Room

10:00 A.M. Call to Order—President Wertheimer

Early Bird Attendance Prize

Address of President Samuel Wertheimer

Report of Executive Secretary—Nathan I Gruz

Prize Drawings

"Drug Abuse—Enforcement and Education'

John Finlator, Associate Director, Federa Bureau of Narcotics and Dangerou Drugs—"The Federal Program on Dru Abuse"

Michael R. Sonnenreich, Deputy Chief Counsel, BNDD—"A Federal Omnibus Narcotics and Dangerous Drug Bill"

George B. Griffenhagen, Editor, APhA Journal and Founding President, Nationa Coordinating Council on Drug Abus Education and Information—"The Pharmacist's Role in Drug Abuse Education

Announcements

Prize Drawings

Adjournment

10:00 A.M. LAMPA—Bus Trip and Fashion Show

Entertainment Features:

2:30 P.M. Renewal of Baseball Classic—Pill Rollers v Pill Pushers (TAMPA)

9:30 P.M. Tamiment Cabaret Show — Dancing — Bal room

WEDNESDAY, JULY 16—THIRD SESSION—
Constellation Room

9:30 A.M.—Call to Order—President Wertheimer

Early Bird Prize

"Continuing Education for Pharmacists—I Choice or Law?" — Dr. Warren Weaver, Dean, School of Pharmac Medical College of Virginia and Pre dent of the American Association of C leges of Pharmacy

Panel Discussion—"Prescription Prepayme Plans" — Panelists: Ira L. Shareno New York Blue Cross; Benjamin Jaffe, Administrator for Union Plai Robert F. Steeves, Pharmaceutical Ca System (PCS); and Robert E. Abrai "Paid Prescriptions."

Entertainment Features:

11:00 A.M. LAMPA Annual Meeting and Luncheon — Wig Show—Prizes, gifts—Luncheon in honor of LAMPA Corresponding Secretary Mrs. Richard R. (Ann) Crane.

9:30 P.M. TAMPA "Las Vegas Night"
Tamiment Entertainment

THURSDAY, JULY 17—FOURTH SESSION—
Constellation Room

9:30 A.M. Call to Order—President Wertheimer

Early Bird Attendance Prize

Communications

Memorial Services

Report of Legal Counsel—Joseph S. Kaufman

Report on the Maryland Medical Assistance Program—Donald O. Fedder and Gordon A. Mouat

Old Business

New Business—Resolutions

Report of Nominating Committee

Election of Officers and Members of the Executive Committee

Election of Nominees for the State Board of Pharmacy

Resolutions

Prize Drawings

Adjournment of the Convention

Meeting—MPA Officers and Executive Committee

:00 A.M. TAMPA Annual Meeting—Library

tertainment Features:

:30 P.M. Reception—Cocktails and Hors d'oeuvres

:30 P.M. Annual Banquet—Main Dining Room
Awards
Installation of Officers

:30 P.M. Dancing and Entertainment

EASE NOTE: Badges Must Be Worn At All Times

Banquet Tickets Available for Those Not Registered at Tamiment at $10.00 per Person. The Banquet is considered a Part of the Hotel Convention Rate.

Breakfast will be served from 8:00 to 9:30 A.M.

uncheon will be served from 1:00 to 2:00 P.M.

Dinner will be served from 7:30 to 8:30 P.M. except for Banquet

Donors of gifts, prizes and favors shall be announced hroughout the events of the Convention

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Convention Speakers

JOHN FINLATOR

John Finlator was appointed an associate director of the Department of Justice's newly created Bureau of Narcotics and Dangerous Drugs, on April 8, 1968. He was appointed Director of the Food and Drug Administration's Bureau of Drug Abuse Control (BDAC) March 7, 1966. Veteran of more than 30 years of Federal Service, he was formerly Director of the Office of Manpower and Administration, General Services Administration.

He is a native of Raleigh, North Carolina. Earned his BS at North Carolina State University in 1934 and studied personnel and administration at American University's Graduate School from 1943 to 1945. He was also an instructor with the U.S. Department of Agriculture's Graduate School. Prior to assuming his post with GSA's Office of Manpower and Administration in 1962, he was Director of the Systems and Procedures Division at GSA for five years and Regional Management Officer with the Post Office Department for three years.

Mr. Finlator served as Executive Officer, Bureau of Security and Consular Affairs, Department of State from 1952 to 1954, and Acting Director, Public Administration Division, Institute of Inter-American Affairs for two years prior to that assignment. He also served as Assistant Executive Officer with the State Department's Personnel Office, Special Agent with the Department of State, and Investigator for the Civil Service Commission.

Mr. Finlator is the immediate past National President of the Association of Federal Investigators. He will discuss "The Federal Program on Drug Abuse."

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MICHAEL R. SONNENREICH

Michael R. Sonnenreich is the Deputy Chief Counse Bureau of Narcotics and Dangerous Drugs of the Depar ment of Justice. He also serves as a Special Assistant to th U.S. Attorney for the District of Columbia.

Mr. Sonnenreich attended the University of Madri received an A.B. degree from the University of Wisconsi in 1960 and an LL.B. from Howard Law School in 1963.

He has been admitted to the bar in the District Columbia and to practice before the U.S. Supreme Cou and the U.S. Court of Military Appeals.

Mr. Sonnenreich is a lecturer on International a Comparative Law at the U.S. Army Judge Advocate Ge eral's School.

He is a consultant to the Special Committee on N cotic and Hallucinogenic Drugs Act—National Commissi on Uniform State Laws.

He is the author of a number of publications includi the Handbook of Federal Narcotic and Dangerous D Law (Government Printing Office, January 1969) "Drug Abuse: New Legislation, New Trends."

Mr. Sonnenreich will discuss the new Proposed On bus Drug Bill, which he has helped to develop.

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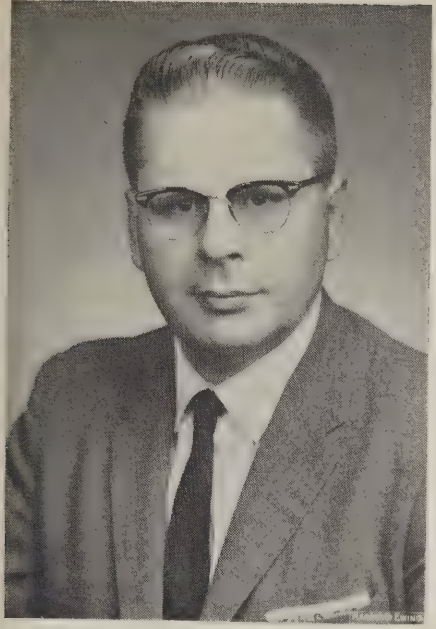


GEORGE B. GRIFFENHAGEN

George Bernard Griffenhagen, registered pharmacist, has practiced his profession as a community practitioner, hospital pharmacist, pharmaceutical educator, manufacturing pharmacist, pharmaceutical historian and museum curator, and now as an association executive and pharmaceutical journal editor.

Mr. Griffenhagen currently serves as APhA Assistant Executive Director for Communications and as Editor of the Journal of the American Pharmaceutical Association. He is a graduate of the University of Southern California School of Pharmacy with both a Bachelor of Science of Pharmacy (1949), and a Master of Science in Pharmaceutical Chemistry (1950).

International relations is a field in which George Griffenhagen has had considerable experience. He served as Secretary General of the Fourth Pan American Congress of Pharmacy and Biochemistry held in Washington, D.C. (1957) and currently is serving his second three-year term as First Vice President of the Pan American Pharmaceutical and Biochemical Federation. He has served as a U.S. delegate to the International Pharmaceutical Federation Assemblies in London (1955), Brussels (1958), Copenhagen (1960), Vienna (1962), Amsterdam (1964) and Hamburg (1968). He currently serves as a member of the Commission on the Future of FIP. In recognition of his nternational activities, Mr. Griffenhagen was the first U.S. pharmacist to receive the Squibb Pan American Pharmaeutical and Biochemical Award (1963). He holds honorary memberships in the national pharmaceutical associations f Argentina, Chile, Cuba (in exile) and Mexico.

As a pharmaceutical historian, Mr. Griffenhagen served even years as curator of the Smithsonian Institution Diision of Medical Sciences (1952-59); as president of the American Institute of the History of Pharmacy (1960-61); s president of the Friends of Historical Pharmacy (1957-8);and as secretary of the American Pharmaceutical Association Section on Historical Pharmacy (1952-59). He currently serves as Vice President of Union Mondiale Societe d'Histoire Pharmaceutique. He has written nearly one hundred publications on the history of pharmacy and has contributed to the literature on various other subjects including pharmaceutical philately and pharmaceutical practice.

In 1964, Mr. Griffenhagen received the Pfizer Merit Award of the U.S. Civil Defense Council for contributions in the field of disaster preparedness and he received a meritorious service citation from the American National Red Cross. During 1963-1964, he served as Project Director of the national experimental study to evaluate "The Pharmacy as a Health Education Center" conducted under a $100,000 U.S. Public Health Service grant. In July 1968 he was elected Chairman of the National Coordinating Council on Drug Abuse Education and Information.

He served as president of the City of Washington Chapter of the American Pharmaceutical Association (1958-59) and is a member of numerous organizations, including the honor societies of Rho Chi, Sigma Xi and Phi Kappa Phi.

He served three years in the U.S. Army during World War II, with 30 months overseas duty in North Africa, Sicily, England, France, Belgium, Germany and Czechoslovakia. Subsequent travel has taken him to over 30 different countries.

Mr. Griffenhagen will speak on "The Pharmacist's Role in Drug Abuse."

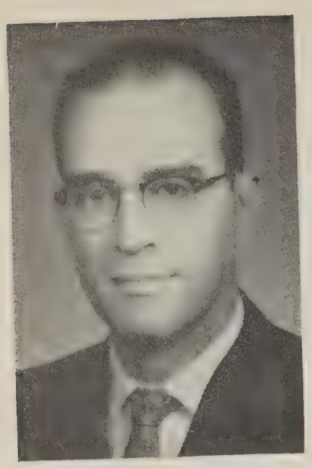
Job Advantages Get Different Rating from Bosses, Personnel

Which term do you use in your business—*employee* relations or *human* relations? One reason why the second is better than the first is implicit in this example:

A leading management consultant, Dr. E. Herbert True, administers a standard test to both employees and management of client concerns. It consists of seven job characteristics, which the individuals are asked to rate numerically in their order of importance. Results, published by *Industrial Banker,* demonstrate how differently the two echelons react, as averaged over a period of years.

Employers evaluate the benefits as follows: 1. Good wages. 2. Job security. 3. Advancement opportunity. 4. Good working conditions. 5. Help with personal problems. 6. Appreciation for good work. 7. Sense of belonging.

But the two rewards that management puts at the bottom come first returns by employees—who relegate management's No. 1 to fifth place on their scale of values. Here is the way that workers grade the seven advantages: 1. Appreciation of good work. 2. Sense of belonging. 3. Advancement opportunity. 4. Job security. 5. Good wages. 6. Help with personal problems. 7. Good working conditions.



WARREN E. WEAVER

Dr. Warren E. Weaver, Dean, School of Pharmacy, Medical College of Virginia is a native of Baltimore County. He received his B.S. in Pharmacy at the University of Maryland in 1942 and his Ph.D. in Pharmaceutical Chemistry in 1947. He is a registered pharmacist in Maryland and Virginia.

In 1950, Dr. Weaver joined the faculty of the Medical College of Virginia as Associate Professor of Pharmaceutical Chemistry. He was promoted to Professor Chemistry and Chairman of the Department of Chemistry and Pharmaceutical Chemistry in 1954. In 1956, he was elevated to his present position as Dean.

Active for many years on the Hospital Pharmacy Education, Educational Policies and Executive Committees of the American Association of Colleges of Pharmacies, he was elected its President for the current year.

Dean Weaver has been active and held posts in numerous professional and scientific organizations. He was elected Chairman of the Virginia Section of the American Chemical Society in 1963 and was Editor of its "Bulletin" from 1955 to 1958. He served as Treasurer of the Virginia Pharmaceutical Association and was named "Pharmacist of the Year in 1963."

The Friends of Historical Pharmacy named him Secretary-Treasurer from 1960 to 1966 and President, 1966-67.

Dean Weaver has been involved in the following capacities in the health care area: Secretary, Virginia Council on Health and Medical Care, 1967-1969; Consultant — Bureau of Health Manpower—1966-1968; Member—Construction of Schools of Pharmacy Review Committee in the Bureau of Health Manpower, HEW, 1968 to the present; and Consultant—Virginia Regional Medical Program, 1968 to the present.

The American Foundation for Pharmaceutical Education elected him to its Board of Directors this year. He also holds memberships in many other groups including A.Ph.A., A.C.A., A.A.A.S., (fellow), Rho Chi, Phi Delta Chi and American Institute of the History of Pharmacy.

He has published extensively in the fields of insecticides, amino acids, fungicides and pharmaceutical education.

Dean Weaver was selected by the University of Maryland School of Pharmacy Alumni Association for the 1969 "Honored Alumnus Award."

He will speak on "Continuing Education for Pharmacists—by Choice or by Law?"

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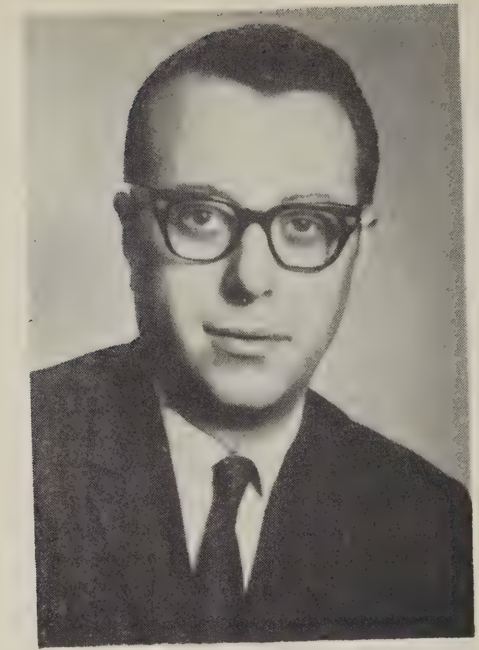

IRA L. SHARENOW

Ira L. Sharenow, a pharmacist and attorney is Director of Planning Services, Associated Hospital Service of New York (Greater New York's Blue Cross). In this position, he coordinated the development of the Blue Cross Prescription Program and the Blue Cross - Blue Shield Dental Program.

He was educated at Fordham University College of Pharmacy, receiving his B.S. in Pharmacy in 1955, and at Columbia University School of Law, obtaining an LL.B. in 1958.

Mr. Sharenow served as Assistant to the Executive Secretary of the Pharmaceutical Society of the State of New York from 1959 to 1967.

He holds appointments as Assistant Professor of Pharmaceutical Law, Fordham University College of Pharmacy and Lecturer in the graduate course of Pharmaceutica Socio-Economics at Columbia College of Pharmaceutica Sciences.

Mr. Sharenow is a panelist in the program on "Prescription Pre-payment Plans."

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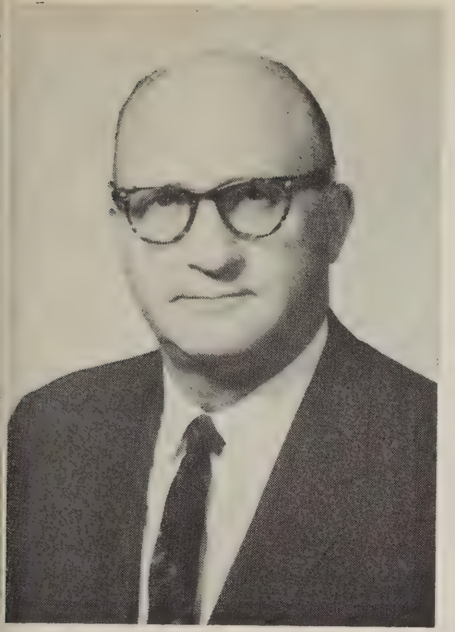

IRVING RUBIN

Irving Rubin, editor and publication director of the *American Professional Pharmacist,* has over 25 years' experience as a pharmaceutical editor. He has also served as pharmacist and manager of community pharmacies and as chief pharmacist of a 1000-bed hospital.

In 1936, Mr. Rubin was graduated—cum laude—from he Brooklyn College of Pharmacy. In 1948, he earned a B.A. degree in English.

In addition to membership in many professional societies, Pharmacist Rubin is a member of the Board of Trustees, Brooklyn College of Pharmacy, and an honorary member of three pharmaceutical fraternities—Alpha Zeta Omega, Rho Pi Phi and Delta Sigma Theta.

In 1963 he was awarded the First Annual Alumni Achievement Award by the Alumni Association of the Brooklyn College of Pharmacy. In 1964 he was awarded ertificates for editorial achievement by Alpha Zeta Omega Pharmaceutical Fraternity and by the American Cancer Soiety. He received the 1968 Annual Achievement Award—resented by Alpha Zeta Omega Pharmaceutical Fraternity—for meritorious contribution to Pharmacy and its allied ciences.

Mr. Rubin has served as chairman and co-chairman of everal Remington Medal Dinners. Some of the many projects he initiated editorially include: The Pharmacist's oath, nd the need to change the pharmacy curriculum to inude such subjects as surgical supplies and detailing. He urrently is urging *required* under-graduate courses in intitutional and clinical pharmacy.

Mr. Rubin has appeared on the Convention program of many pharmaceutical groups, including MPhA in 1962 and 967. His topic this year is "Ten Ways to Beat the Disounter."

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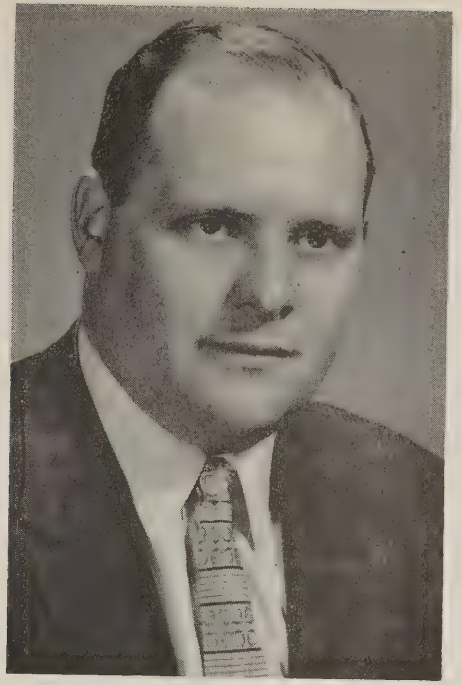

ROBERT E. ABRAMS

Robert E. Abrams, who has been appointed President of "Paid Prescriptions, Inc.," has distinguished himself as a leader in programs to enhance the position of pharmacists as health professionals.

Mr. Abrams received a B.S. in 1949 and an M.S. in 1950 from the Philadelphia College of Pharmacy and Science. He was awarded an honorary Degree of Doctor of Science from the Massachusetts College of Pharmacy in 1964.

He served on the faculty of P.C.P.S. following graduation and attained the rank of Professor of Pharmacy Administration. He concurrently served as the Executive Secretary of the American College of Apothecaries (ACA). He became well known as the Editor of "The Voice of the Pharmacist." In 1965 he left A.C.A. after 13 years to become Director of Distribution and Institutional Sales Development for Roche Laboratories.

Mr. Abrams was installed last month as 1st Vice President of the American Pharmaceutical Association. He has been active in the Administrative Section of the American Academy of Pharmaceutical Sciences. He has done extensive research in pharmaceutical economics, published widely and has addressed a majority of the state pharmaceutical associations. He addressed the MPhA in 1959 and the BMPA in November 1961 at the first meeting following the appointment of Nathan Gruz as MPhA and BMPA Secretary.

Mr. Abrams has received the following honors: J. Leon Lascoff Memorial Award; Pennsylvania Junior Chamber of Commerce Young Man of the Year Award; Kauffmann Lecturer, Ohio State University; Kremers Lecturer, University of Wisconsin; Philadelphia Chapter American Pharmaceutical Association Achievement Award.

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for both sides of the counter—in fast, ef
deliveries, in accurate modern billing me

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MPhA Message to Pharmacy School Seniors

Nathan I. Gruz, Executive Secretary,
Maryland Pharmaceutical Association

In these remarks presented at the Senior Assembly of the University of Maryland School of Pharmacy on May 26, 1969, the role of various state and local pharmaceutical groups is outlined. The graduates—as the crucial segment of pharmacy were urged to participate in and improve organized pharmacy.

I am delighted to have the opportunity to speak to you, the graduating class of 1969 on behalf of the Maryland Pharmaceutical Association as well as to urge you to participate in the other organized groups in the State which may be relevant to your interests and geographic location, namely: the Maryland Society of Hospital Pharmacists, the Allegany-Garrett Pharmaceutical Association, Baltimore Metropolitan Pharmaceutical Association, Eastern Shore Pharmaceutical Society, Prince George/Montgomery County Pharmaceutical Association and Washington County Pharmaceutical Association. I have always considered it a most gratifying privilege to talk briefly at the Senior Assembly held at this time each year.

In my opinion you young people represent the crucial segment of pharmacy. You are the ones that will be part of a new, concerned generation in pharmacy. The students of today—and I saw this demonstrated by the students at the APhA Convention in Montreal—have placed the highest priority on the human requirements of society and on being part of a system of delivery of health care available to all. This is in contrast to much of what has been and is today the primary concern of much of our society—namely, economic self-interest untempered by the public interest.

Now, how can you, entering the profession of pharmacy, translate this great motivation, this great concern for the welfare of your fellow man into concrete results. To be realistic, as well as idealistic, this concern must also provide you, the young pharmacists entering pharmacy practice with professional, economic and personal opportunities. These opportunities must provide for growth. You will find that personal growth is linked with growth as health professionals. Finally, this growth based to a great extent on service to patients, to community, to society and to the profession, will bring its economic rewards. This has been the experience of the men and women who have been successful leaders in pharmacy.

Here is where your professional associations come in. Today our society is made up of thousands of organizations representing every profession, every industry, every special interest. The place of each such interest—of each vocation—is dependent upon the strength and effectiveness of the organization representing that special interest.

Pharmacists for the most part have been notoriously negligent and apathetic in their inadequate support of their societies. A relatively small portion of the total body of pharmacists has supported the pharmaceutical associations, compared to some other health professions.

Nevertheless, the Maryland Pharmaceutical Association is the recognized, representative body of pharmacy for the State of Maryland. The law requires the Governor to appoint members of the Board of Pharmacy from the list submitted to him by the MPhA. The Board must report to the MPhA. We are consulted regarding pharmacists to be appointed to agencies such as the Board of Health and Mental Hygiene, Medical Care Advisory Committee, the Hospital Licensing Board and others. We maintain liaison with the Governor, the Mayor and numerous other executive, legislative, administrative and governmental groups. We meet regularly with the Medical Society as part of their committees. The other health professions, voluntary health agencies and every facet of the community recognize the MPhA and contact us in matters involving pharmacy, drugs and health care.

MPhA is responsible for the enactment of the State Pharmacy Law. In the past years, we have secured landmark amendments hailed as models throughout the country. Both the "practice of Pharmacy" and what a "pharmacy" is have been re-defined. The advertising of legend drugs is banned, as well as references to the prices of prescriptions. We have furthered the self-policing of pharmacy—one of the marks of a true profession—by obtaining authority for the Board of Pharmacy to promulgate regulations regarding the practice of pharmacy. The kind of unprofessional conduct liable to suspension or revocation of a license has been defined through our organized efforts and leadership.

Through the efforts of MPhA, pharmacy education has been elevated. Requirement in the law was obtained for a curriculum and course of study of academic standing. First for 2 years, then 3, 4, and now 5 years. We championed continuing education programs, resulting in MPhA seminars and in the expanding role of the School itself in this vital area today.

The Medicaid Program and before it, the Medical Care Program has been a major concern. MPhA succeeded in obtaining increased in the compensation for professional services three years in a row. Budgetary factors resulted in a decrease in fee last year, but through our efforts it will be restored on July 1st this year. In addition, we have worked out a procedure with the State for expediting payment of pharmacy bills unpaid for long periods of time.

We are setting up a "Committee on Personnel Relations" or as the students at the APhA Convention preferred "Intra-professional Economic Relations." This is intended to be a means of meeting the problems of the relations of employer to the staff pharmacist.

The MPhA is involved in a long list of other activities which can only be touched on today. These include interprofessional relations, public health, education and information, recruitment of students and scholarships.

(*Continued on Page* 25)

cosmetic corner

BY ELOISE SOPOCY

shaving---or depilatories?

According to figures we read in a survey, 85% of American women over 14 remove unwanted leg, underarm or facial hair.

For removing hair from legs and underarms, most women prefer shaving, probably because it's the fastest method. However, for removing facial hair (and in many cases for leg hair) many women prefer to use a depilatory. Do you know the answers to the questions your customers ask about depilatories?

1. Are depilatories safe to use? For most people, yes. If your customer hasn't used a depilatory before, it would be advisable for her to put a small amount on a relatively hairless surface of the inner arm for about thirty minutes. If there are no signs of redness or irritation after that time, it would be safe to proceed on a hairy area.

2. Does shaving or using a depilatory increase the growth of hair? The American Medical Association says that tests have proved that using a depilatory or shaving will not affect the rate of growth, the thickness or any other characteristic of the hair.

3. Can depilatories be used in the underarm area? Although there are a few on the market that say, "Safe for use on underarms," most dermatologists do *not* recommend using a depilatory in this area. Shaving is effective and easy in the underarm area, and because of the warmth in that area, irritations from depilatories are more frequent.

4. Are wax depilatories more efficient than chemical ones? Probably they are, but they are also more painful so most women prefer the chemical ones. One eminent dermatologist says that frequent use of wax depilatories may cause some damage to the hair follicles causing hair to grow in either thicker or at less than normal size. No such results have been found with the chemical depilatories.

5. Does hair grow in more slowly after using a depilatory than after shaving? Not really. Neither process affects the growth of hair, but since a chemical depilatory works by softening the hair shaft and decomposing it, the hair does not grow in bristly and therefore does not seem to be growing in as fast.

6. Can all depilatories be used on the face? Definitely not. Recommend for your customer's use only the depilatories which plainly state on the label that they may be used on the face. The ones that have this statement generally contain a cream to act as a neutralizer and keep the face from becoming irritated.

7. What are the most frequent mistakes that people make in using depilatories?

First, as with so many other products, they don't follow directions. Timing with depilatories is very important and the manufacturer's directions should be followed exactly.

Second, a depilatory should never be used where there is a break in the skin.

The Last of the Pioneers

Recently we had the opportunity to talk with one of the executives of the Dorothy Gray Company who said, "Dorothy Gray visited our office in the spring of 1968 and was a joy to behold, tiny, petite, very stylishly dressed. Her hair was short and brownette. She was really a walking ad for her theories and her profession. At a casual meeting, most people would guess her age as 50 to 55 years, but she was probably 81 at the time. She was very bright and very alert."

A great tribute, we think, to one of the cosmetic pioneers.

Dorothy Gray's father was a world famous dermatologist who spent hours working with his daughter to help her develop her skin care preparations.

Miss Gray opened her first salon at 57th Street and Madison Avenue in New York in 1916. Women came from all around to learn her beauty secrets. Her massage techniques became world famous. At one time her hands were insured for $100,000.

At that time many women were spending a great deal of money on "peeling" and "cutting" and other "popular" ways to acquire a more youthful look. They were most anxious to find out about Miss Gray's more natural methods.

In 1926, Miss Gray moved her salon to Fifth Avenue, and as her clientele expanded, prestige stores wanted retail distribution rights for her products. Soon her preparations became available on a national basis in selected franchise accounts.

Some of the products in the Dorothy Gray line today are still her original formulas.

Miss Gray died in August, 1968, in Hollywood, Florida—the last of the beauty pioneers.

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Now's the time to sign up this upcoming CALADRYL star. It's the profit-wise way to set the stage for the rush of sales that follows the summer rash of insect bites, mild poison ivy and oak, and light sunburn.

New CALADRYL Spray offers extra convenience along with soothing relief. Antipruritic and antihistaminic, it's sure to be a hit with your customers.

So be sure to include CALADRYL Spray in your summer stock plans *today*. See your Parke-Davis representative for details about this new product and display materials. And stock up on the regular CALADRYL dosage forms too.

SUPPLIED: CALADRYL Lotion—6-oz. glass and 2½-oz. plastic squeeze bottles. CALADRYL Cream—1½-oz. tubes. CALADRYL Spray—2-oz. and 4-oz. cans.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

MPhA Message

(Continued from Page 22)

Association services include legal counsel, employment assistance, insurance and pension programs and others.

MPhA has sought the participation of every pharmacist regardless of his field of practice—community, hospital, education, law enforcement and so forth.

So, what is the course of action for you, the graduate of 1969?

The only reasonable response is to take advantage of the machinery available to you for professional and personal growth.

The machinery, we admit needs improvement and revitalization which only you can bring.

You are receiving 18 months complimentary membership for the balance of this year and all of 1970.

You are urged to become active immediately. Tell us on which committee you would like to serve. Let us know your interests. Let us have your comments, ideas, suggestions and constructive criticism.

As Executive Secretary, I am urging the inclusion of young pharmacists and students too, in a House of Delegates structure which is planned for this year.

We urge you to feel free to contact the Association Office and me, personally, for any service we can provide. Please stop in at any time.

Yes, MPhA needs you and welcomes you. But, in your own self-interest, if for no other reason, you need a strong association. You can make it stronger if you will take the time and effort to do so.

So, on behalf of the officers and members of the MPhA, as well as all the other bodies in the complex of pharmacy in Maryland, congratulations and best wishes for a long and useful career on behalf of better health for all people.

Expiration Date for Squibb Rx Items—

E. R. Squibb & Sons, Inc., announced the successful completion of a test program that will help guarantee that both the pharmacist and the consumer will receive fresh, full-potency drug products throughout the Company's entire line of ethical prescription drugs. The two-year-old test program involved the posting of expiration dates on a group of products that do not legally require such notice. Current FDA regulations affect only one-third of Squibb's drug products.

"Although we are not required by law to place expiration dates on all ethical drugs," said Michael Bongiovanni, vice-president-marketing, "we felt that such an innovative step in our company would be a further guarantee of product quality. We believe that the new program of expiration dating should also assist the pharmacist in determining the freshness of his products, and help him when he inventories products to be returned.

"The results of this testing have been extremely encouraging," Mr. Bongiovanni noted, "and Squibb will now provide an expiration date for a range of 400 list numbers. Of this group, to date, 50 list numbers in Squibb's product line already carry dating."

The company expects that all ethical drug products will be dated within the year.

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Profit is the name of the game. And what you as a business man should be concerned with is product profitability. Let's talk dollars and cents about paperbacks and magazines.

For every $100.00 invested in paperbacks and magazines you can expect a return of $127.00. You can expect this return within 30 days of the initial outlay. There is no problem with unsold copies, they are fully returnable.If it doesn't sell, it's moved out and replaced by books and magazines that move.

Magazines, paperbacks, comics and children's books also build traffic, lead to related sales, dress up your store and advertise all the products you carry.

It's simple and direct. No charts, no graphs, just plain dollars and sense.

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AS I SEE IT
STM '68

Samuel L. Fox, Ph.G., M.D.

The Clinical Pharmacist

Because of previously expressed opinions, I have been accused of demeaning the pharmacist and the plans for future training and education of pharmacists. Nothing could be further from the truth. If ever anyone needed proof of the change in attitude of practicing pharmacists in this State, it was evident at the recent Robert L. Swain Pharmacy Seminar co-sponsored by the School of Pharmacy and the Maryland Pharmaceutical Association. A full 9 hour day of post-graduate seminars, lectures and exhibits was devoted to "The Pharmacist's Responsibilities in Ophthalmology." Approximately 100 busy pharmacists registered and attended this course! I interpret this aroused interest in "keeping up" as the healthiest sign that I have seen to indicate that pharmacy is alive and kicking and is not going to succomb to the ills of the times. The men and women in attendance were of all ages and the majority were independent practitioners in communities. They felt it was worthwhile for them to give up a full day of their activities to a program of renewed learning, and they are to be commended for their wisdom and good judgement. It is only by attendance at such programs of "continuing education" (as it is now called) that the members of any profession can keep abreast of the new scientific progress in their field. It was heart-warming to me to address such a meeting.

There is no question in my mind that the pharmacist of the future will, of necessity, have to be better trained in pharmacology and the action of drugs than ever before. It will not be enough to know that a drug is an "antispasmodic" and the various forms in which it is available from the manufacturer. The Physicians Desk Reference (PDR) will provide this information readily and every physician is provided a copy by the publisher *gratis*. It is universally available, therefore.

As the medical curriculum expands into newer disciplines and broader areas of knowledge which must be imparted to the student, the older and more orthodox subjects (such as anatomy, biochemistry, pharmacology and physiology) must tailor their courses and trim away much of the time formerly devoted to traditional teaching in order to make room for the newer knowledge in an ever-expanding field. Hence, the physician of the future will know less about the details of the drugs which he is called upon to prescribe for his patients. He will have a broad over-all knowledge of the various classifications of drugs, and he will have great depth of understanding about certain drugs which he employs in the confines of his special interests, but he will, of necessity, be dependent upon the knowledge of the pharmacist to assist him in the selection of specific preparations of drugs within the categories he chooses for the treatment of the patient.

My point has been, and remains today, that the physician must and will retain control of the process of diagnosis and the determination as to which categories of drugs are to be employed in treating the patient. He will probably not be able to write specific prescriptions as readily as he does now; certainly this will be true on the day of his graduation from medical school. The responsibility of the pharmacist will broaden to encompass service as a technical advisor to the physician in the selection of the exact preparations which might be best for any given patient or disease. The pharmacist must also prepare himself for the more exacting role of being able to assist in the formulation of new dosage forms for trial in clinical research in hospitals. The physician is not, by training or interest, usually capable of dealing in the science of pharmaceutics. This is the province of the pharmacist.

Stated another way, I feel that the pharmacist will enjoy a more important role in the health team of the future. He will be called upon by the physician to advise on suitable drug preparations and dosage forms of drugs which the physician requires for the treatment of his patients. This does not imply that the physician will make a diagnosis of pneumonia, take a culture, and send the results to the pharmacist for his selection of the proper antibiotic and the dosage schedule for such medication. This would be disastrous for the patient. Yet, some pharmacists and educators would give the impression that this is the pattern for the future. It cannot be and it dare not be. To say that there can only be one captain on a team is not to assign the other members of the team to roles of insignificance.

Medicine, to say the least, is not an exact science. Each patient must be dealt with as an individual. As soon as the practice of medicine takes on the attributes of "mass production" and impersonal relationships, it fails miserably to serve the sick. This has been shown repeatedly, and is the greatest deterrent to "socialized medicine" that I know. In addition, the human being does not respond to the exact rules of science and the science of pharmacology is no exception to this statement. To understand the tissue reactions which are occurring in the patient, both the beneficial and the adverse reactions, requires a full study of medicine and cannot be acquired by the study of pharmacy. Each profession has its special training and its special expertise; both must complement each other. Medicine cannot slough off its responsibilities for the treatment of patients by preparing and assigning punch cards to a computer programmed by the pharmacist. Neither can pharmacy assum such a task of programming the complete therapy for th sick; it can only advise and assist in selecting the best dru forms for each patient. This is certainly not a demeanin role for pharmacy. It is a role which will require extensio of the curriculum and major revision of the curriculum i the schools of pharmacy. It will require cooperation between the medical school and hospital on the one hand an the faculty of pharmacy on the other, as clinical materi will have to be introduced into the curriculum. In this respect, let me say that this will now require time and a sense of goodwill on the part of all parties concerned.

Formerly the schools of pharmacy had a liberal number of physicians on their faculties. After World War I the "PhD. phobia" took over and schools of pharmacy, including our own, made every effort to establish themselves as independent from the mother discipline of medicine. Physicians were retired from such faculties and replaced by the Ph.D. research chemist or bio-assayist (who became the pharmacologist of pharmacy). Qualified graduates were encouraged to return for graduate study in the pharmaceutical sciences. Soon the curriculum in pharmacy became completely oriented towards the chemistry or manufacture of drug preparations and completely isolated from the clinical usage of these preparations in the patient. Pharmacy is now suffering from this unfortunate decision of its educator leaders of the early 1930's. The chasm between pharmacy and medicine is wider than ever in the history of the two professions, and it will take time to heal and bridge. On the positive side, there is real need for each profession to see that this fissure is healed, as both now suffer and both will benefit by mutual goodwill leading to firm bridging of the gap.

Sound Approach: Let George do it!

Associations have a *patois* of their own, and one of its overworked phrases is about "George" and not letting him do it. Taken literally, it means every member is on his own, so far as results are concerned, and the devil take the hindmost. Fortunately, few members heed it and are spared being critized as "too many cooks."

Delegation is the membership organization's key to existence, as much as it is in government, and more so than in business. Committees are the butt of countless quips, but can you picture all the members drafting a budget, planning a convention program or wording a questionnaire? What if detailed actions and expenditures required prior approval of the membership, and there were no board of directors or executive committee to govern between conventions? Or if committees tried to do everything, without delegation to staff?

Associations are a vital force in our civilization because they effectively marshall the most inspired and devoted individuals in the common cause, and give them responsibility for results. This is practical because, in every area, some are more widely experienced, better informed or naturally talented than others. But since rotation is the general rule, everyone gets a chance to bat, if he is qualified.

Of course, officers, chairmen and committee members don't build walls around themselves and their projects. They often appeal for reactions and suggestions—and sometimes for assistance. Ready compliance is one sign of a good member.

There are always areas where individual contributions really count, including active participation in meetings, writing articles, responding to surveys and influencing eligibles to join. But where responsibility is delegated, the best rule is: Pick "Georges" carefully—then help them do it!

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60,000,000
vacationers to
hit the road
this summer

Good News

about products & profits from A. H. Robins

Forecast:
Hot deals
followed by
heavy buying

TWO NEW DEALS!

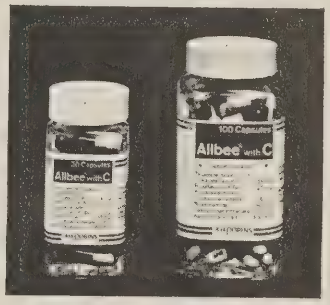
Donnagel® Deal Made to Order for Summer Diarrhea

During April and May druggists all across the country will be able to purchase Donnagel at special bargain deal prices. What better time to stock up on the outstanding medication for traveler's diarrhea and its discomforts. It's the antidiarrheal that also contains antispasmodic ingredients. Your Robins representative will be around soon with the details. Order heavy and be prepared for big summer sales and profits.

A Good Traveling Companion

Allbee® with C, All-Season Vitamin, on Deal in 2 Sizes

From April 1 - May 31 you can stock up both on Allbee with C 30's and 100's during A. H. Robins' chance of a springtime deal. Your Robins representative has a special offer, but we promised not to steal his thunder, so he'll tell you all about it the next time he comes around. Summer's a good time to sell America's leading B-complex with C Product. And remember, dentists prescribe it more than any other vitamin.



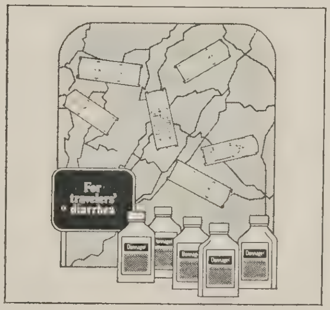
Leading B-Complex with C Vitamin

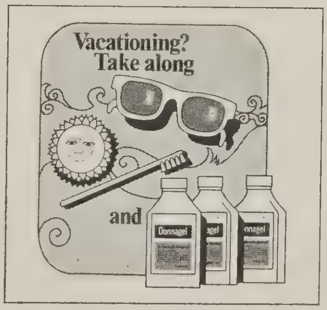
Promote Donnagel as the One for the Road

Homemade Displays Can Increase Summer Sales

Millions of Americans on the move to vacation spots this summer will be wise to take along Donnagel for traveler's diarrhea and its discomforts. But you've got to tell them to sell them. You can make a convincing case for Donnagel by promoting it as an item that's as basic for vacationing as suntan lotion, dark glasses and beach umbrellas.

Whenever you feature vacation and travel items, include Donnagel as an integral part of your display. Ask your Robins representative for a supply of colorful shelf talkers shaped like suitcases. Fit these over or under the plastic Donnagel bottle as a reminder to take Donnagel along just in case.





Homemade displays can also be effective sales aids. All it takes is a few items you have around the store and a little ingenuity. A couple of suggestions: (1) paste a road map of the United States on stiff cardboard and wire some toy cars and airplanes to the surface. Letter on a road sign directing the customer to Donnagel for traveler's diarrhea. Set up your sign next to the Donnagel counter display. (2) using posterboard, cut two slits for a pair of sunglasses, wire on a toothbrush, paste on the sun, letter an appropriate message, and bring out the Donnagel. A. H. Robins is advertising Donnagel heavily to physicians this spring and summer, so be prepared to fill a lot of prescriptions. For extra profits this vacation season, stock, display, recommend, and sell DONNAGEL.

Incidence of Colds, "Flu," & U.R.I. Relatively High During April and May

According to statistics the incidence of colds, influenza, and U.R.I. after dropping in March, tends to level off during April and remain about the same. While not as high as during the winter months, it is about the same as late September. Much of the blame can probably be placed on the fickle spring weather. One day it's warm and dry (almost beach weather), and the next it's snowing and blowing like mid-winter.

You'll still be seeing plenty of customers with spring coughs and colds, so don't put away those Robins cough and cold preps. Keep right on displaying and promoting the complete line of Robitussins and Cough Calmers. And remind your customers that Robitussin-PE® opens clogged noses and clears stuffy sinuses as it relieves coughs.

A. H. Robins Company, Richmond, Va. 23220

The National Association of Boards of Pharmacy—Its Function and Responsibility to the Public and to Pharmacy

Francis S. Balassone
Secretary, Maryland Board of Pharmacy
Director, Division of Drug Control
Maryland State Department of Health

The important role for the profession of pharmacy and the protection of public health of the National Association of Boards of Pharmacy is outlined in this article. It is adapted from the Winter 1968-69 *Issue of the* NABP QUARTERLY *and was originally presented at the 94th Annual Meeting of the New Hampshire Pharmaceutical Association* (1968).

The NABP Executive Committee has taken the position that progress can only be maintained and continued if the vital NABP services to pharmacy and the pharmacist are explained so that you have some knowledge and information about the functions and responsibilities to be derived from the organizational structure of the NABP. This organizational structure benefits both the board of pharmacy, as an administrative agency, the pharmacist who wishes to transfer his license, and ultimately the practice of pharmacy itself. In a few moments I will present you with licensure, reciprocity. If you should ever be in need of the services of NABP, as so many are, we wish to point out the services available and the mechanism of reciprocity.

The National Association of Boards of Pharmacy was founded in 1904 for the specific purpose of providing interstate reciprocity in pharmaceutical licensure. The stated objectives in the constitution in that year 1904, have essentially remained the same. Reciprocity continues to be the basic purpose and objective of the Association. This exchange of interstate licensure is based upon NABP's recommended uniform minimum standard of education and requirements for licensure and practice. This is accomplished through cooperation with member boards of the Association. Since your board is an active participant in reciprocity and has been a member of the Association since 1907, we think it is important that pharmacists in your state, and for that matter, of all states know of NABP's services.

The Association has two responsibilities in maintaining reciprocity: (1) to the applicant who requests our services, (2) to the state board of pharmacy and the people of that state who are served. All boards of this country are members of the Association. We also have provincial members from Canada and other territorial members. Membership is by state. The establishment of NABP was unique in its approach toward the solution to a problem that was recognized in 1904, the exchange of licenses between the states. The drafters of that first constitution were wise enough to recognize the two obligations that such an association might have to the board of pharmacy. The need for the free exchange of licenses and an association that might bring some direction and guidance to standards of licensure are demonstrated by NABP's long record of success.

In pharmacy, there is a free exchange of licenses between 48 member boards of pharmacy and I should point out that this has been maintained without interruption with 47 states since approximately 1914. Now we have 48 states active in reciprocity. As you no doubt know, only California, Florida and Hawaii do not actively reciprocate. Problems surrounding the exchange of licenses in Pharmacy are similar to those in other professions. The NABP has provided a forum where differences between the states could be aired, and more importantly, an organizational structure which serves as a continuing stimulus to active reciprocal membership and the maintenance of uniform legislation and regulations concerned with licensure of pharmacists in all states. In maintaining a file of rules and regulations and statutes over the years in one central office, the Association is in the unique position to help coordinate the activities of the various boards of pharmacy to initiate studies which will pinpoint problem situations and provide a mechanism for their solution in the interest of free and open discussion of licenses from state to state.

The iceberg effect or the unseen benefits derived from the establishment of an Association of boards and its interest in providing pharmacists in this country with a continuing eligibility for transferring their licenses is, I believe, obvious to all those who know the history and functions of the Association. First of all, the Association stands as a reservoir of knowledge available to any pharmacist in the country, and for that matter, boards, colleges and associations. It furnishes information on rules and regulations regarding licensure, reciprocity, internship, examinations, etc. for all states. This is one of the most important tasks that the Association accomplishes each year—the answering of thousands of inquiries from the pharmacists of this and other countries concerning a host of subjects. It is interesting to note that since 1937, the Association has assisted some 40,000 pharmacists in the exchange of their licenses from one state to another. No, the Association does not have a profit motive. In charging this fee, the Association expedites the transfer of an applicant for a pharmacist license and yet this transfer is not solicited in any way.

The pharmacist's privilege of reciprocity is preserved and maintained even though he may never use this privilege.

The pharmacist is referred to the NABP by boards o pharmacy, state and national associations, colleges of pharmacy and individual pharmacists throughout the country We gather information about the applicant through a preliminary application form, furnish the pharmacist with instructions as to filing the application with a state and giv him all of the details and procedures involved. If the applicant is not accepted by the recipient state, the money tha he has paid to the Association is refunded. Not only wa the Association established to promote and to perpetuat reciprocity, but it also serves the important function o eliminating much of the busy work which also accompanie the transfer of a license from state to state.

The fee which is charged by the Association is funneled back to the state boards and ultimately to the pharmacist and the public, through a series of services to the individual board members. You might say that NABP engages in a continuing education program for board members. It assumes some responsibilities in terms of educating a board member to his duties and responsibility while serving on a board. This program is designed to increase the effectiveness of all state boards of pharmacy in this country. This continuing education program is provided through the publications of the Association and by other means. The *Proceedings* of the Association serves as a year book of our activities. The NABP Census and Licensure Data is one of the most authorative publications about the number of pharmacists in this country available to the profession today. The Survey of Pharmacy Laws which gives important information about the uniformity of our state pharmacy statutes is a most often referred to document throughout the profession. Publications such as the NABP Quarterly go to members, state associations, deans, etc. The Association also publishes a Bulletin on special occasions directed to special problems of the Association.

In addition, we publish as a service for interns and preceptors, the Pharmacy Preceptor's Guide and distribute this at cost to all who wish to use it. We continually collect reprints of all laws in each state that affect pharmacy as well as rules and regulations and distribute these to each state board of pharmacy to perpetuate a continuing file in each board office. We publish the NABP Examination Manual which sets down certain procedures recommended by the Association to assist the pharmacy examiner. In addition to this, we have an examination pool that collects questions from all state boards of pharmacy for use by examiners on request. By 1969, NABP hopes to have a standardized examination. We provide legal service to the state boards and at our most recent Miami Convention, were successful in having some 15 assistant attorney generals and counsel attend the meeting and make their contribution to the combined effort of state boards at the national level.

There are many special surveys which the Association does each year. One such special survey has no doubt been brought to your attention and this is the NABP-Public Health Service Manpower Study which is now completed.

Well, these are just some of the things that NABP does for the profession of pharmacy as a whole through its member boards and the individual members who constitute these boards.

Smooth Sailing: Time to Watch Out

Prosperity can be perilous, especially for small business. After a two-year investigation of ruined firms, the University of Pittsburgh's Bureau of Business Research said that many of them failed because they relied on a constant economic updrift to maintain earnings and solvency, instead of diagnosing and correcting their own operational weaknesses. Nine fair-weather hazards emerged from the analysis:

1. Slipshod accounting. 2. Failure to diversify. 3. Investing too much in fixed assets. 4. Too many relatives on the payroll. 5. False confidence, leading to expansion without regard to market limitations. 6. Extending credit without sufficient checking. 7. Failure to detect and shift with changes in buying habits. 8. Neglecting tax considerations. 9. Lack of an organized sales plan.

MPhA's "Your Best Neighbor" Program

Pharmacy Students Broadcast on Drug Abuse

The Maryland Pharmaceutical Association's weekly radio program, "Your Best Neighbor" is broadcast every Sunday Evening on Radio Station WCAO from 10:30 to 10:45 P.M. under the direction of MPhA Public Relations Committee Chairman Charles E. Spigelmire.

Programs on Drug abuse developed by the Student Committee on Drug Abuse Education of the University of Maryland School of Pharmacy were broadcast over a period of several months during the past year. The Students' Committee advisor is Dr. David A. Blake, Assistant Professor of Pharmacology.

After an introductory program entitled "Pharmacy Students in Action" given by Dr. Blake, senior students G. Lawrence Hogue, Paul Grossman, James B. Culp and Thomas Bolling discussed the following topics relative to drug abuse: "The Drug Age," "Drug Abuse and Addiction Definitions," "Alcohol and Marijuana," "Uppers, Downers and Sets—The Amphetamine, Barbiturate Problem," "Trouble in a Tube—The Glue Sniffing Problem" and "LSD—Trips to No Where."

The Pharmacist's Responsibility

"Every pharmacist should take the responsibility of assisting to educate the public on the extremely serious problem of drug abuse and misuse in which there are often many misconceptions being *kicked around,*" Mr. Spigelmire declared. "The pharmacist is qualified to reach the public concerning this problem. Pharmacists therefore *must become involved* in a nation wide program being aimed at educating and making John Q. Public aware of the vastness and complexity of drug abuse. With education, the public can more intelligently cope with the many changing facets of drug abuse."

Left to right: Thomas V. Bolling, Charles E. Spigelmire, Chairman Public Relations Committee, MPhA; James B. Culp, Jr.; Paul Grossman and George Lawrence Hogue.

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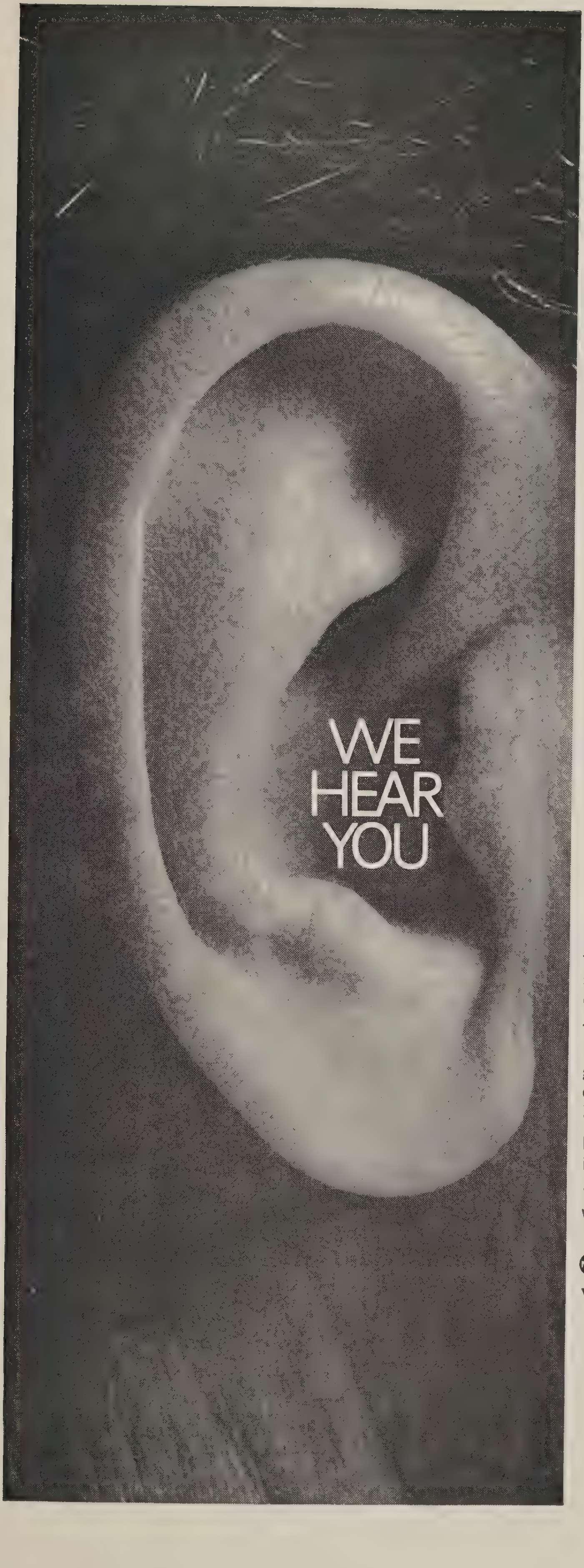

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Division of Merck & Co., Inc. West Point, Pa. 19486
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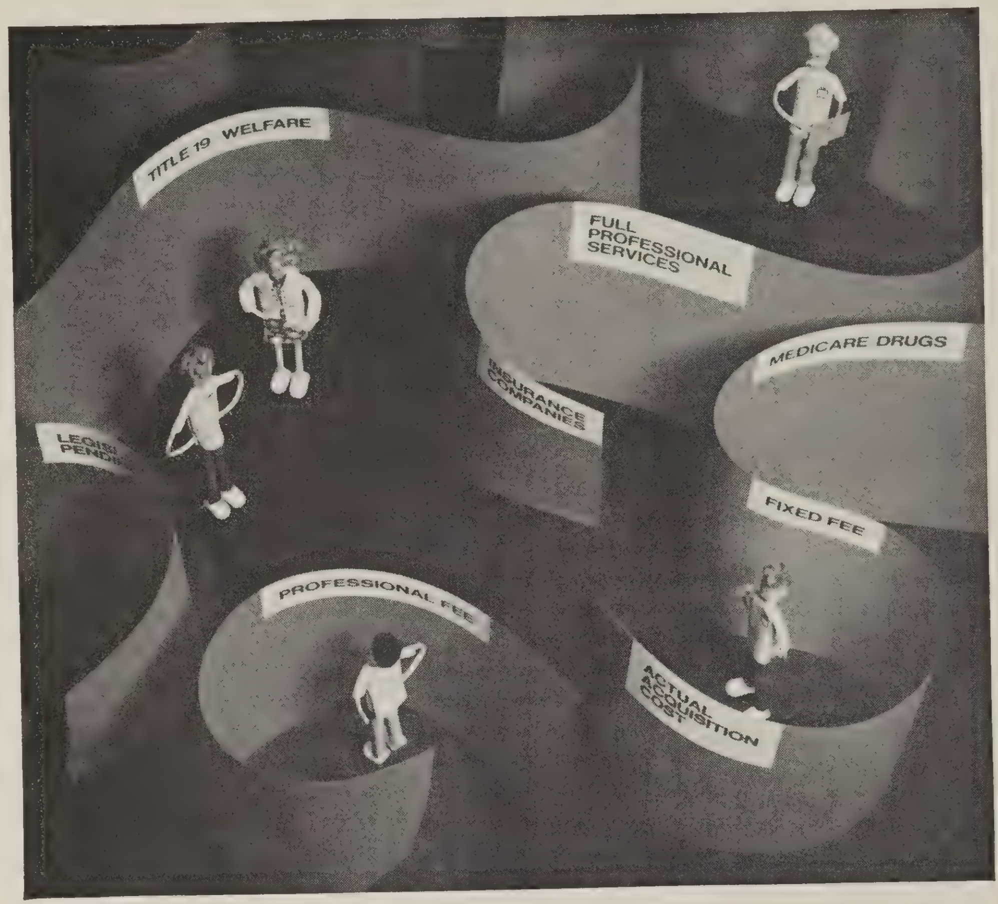
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FIXED FEE
PROFESSIONAL FEE
ACTUAL ACQUISITION COST

Absolutely Amazing!

The era of third-party pay rushes toward us, and with it comes an ever-deepening confusion. The pharmacist finds himself peering into a kaleidoscope of unfamiliar terms, walking in a forest of opinion.

The legislative looms—federal and state—are weaving documents filled with such pharmacy-targeted concepts as mandatory assignment; corridor deductible; maximum allowable cost; actual acquisition cost plus fixed fee.

One thing does seem certain: If the individual pharmacist is to retain his independence and conduct his business as he sees fit, he must make his views known—at every opportunity, in every forum.

The laws are being written. If pharmacists want to have a voice in the preparation, the time is now.

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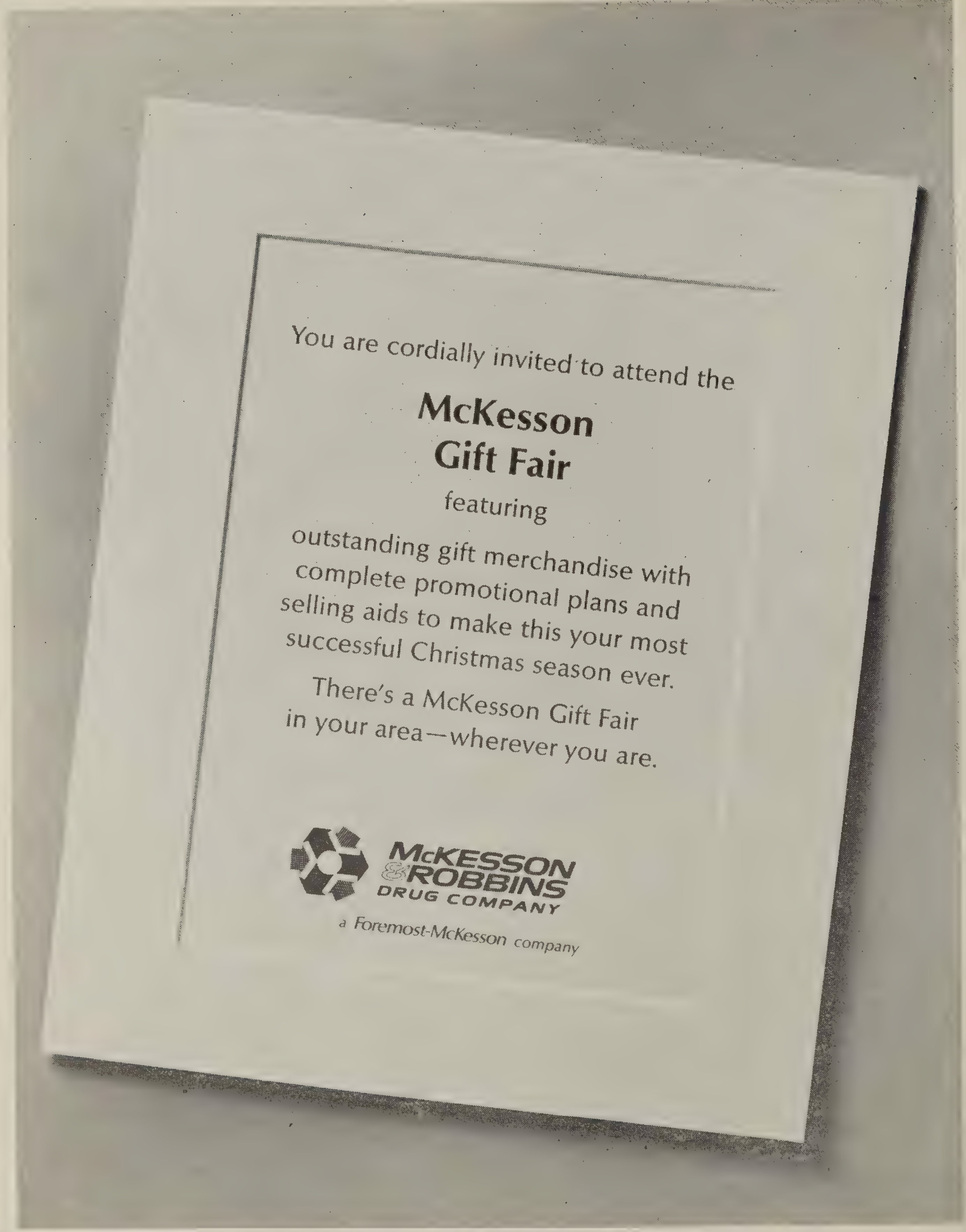

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DIVISION	LOCATION	DATE
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Roanoke	Salem-Roanoke Valley Civic Center Roanoke Blvd. Salem, Va.	July 18, 19, 20

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The Thantis Dispenser, containing foil-wrapped lozenges, provides aseptic dispensing of one or more lozenges.

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the maryland pharmacist

Editorial: *Direct Physician-Pharmacist Telephone Lines*

Handling Professional Samples
Charles S. Bender, FDA

Authorization of Refills
Merl J. Ryan, FDA

Ophthalmic Therapy—Then and Now—Part I
Samuel L. Fox, M.D.

Volume 45 JUNE 1969 Number 6

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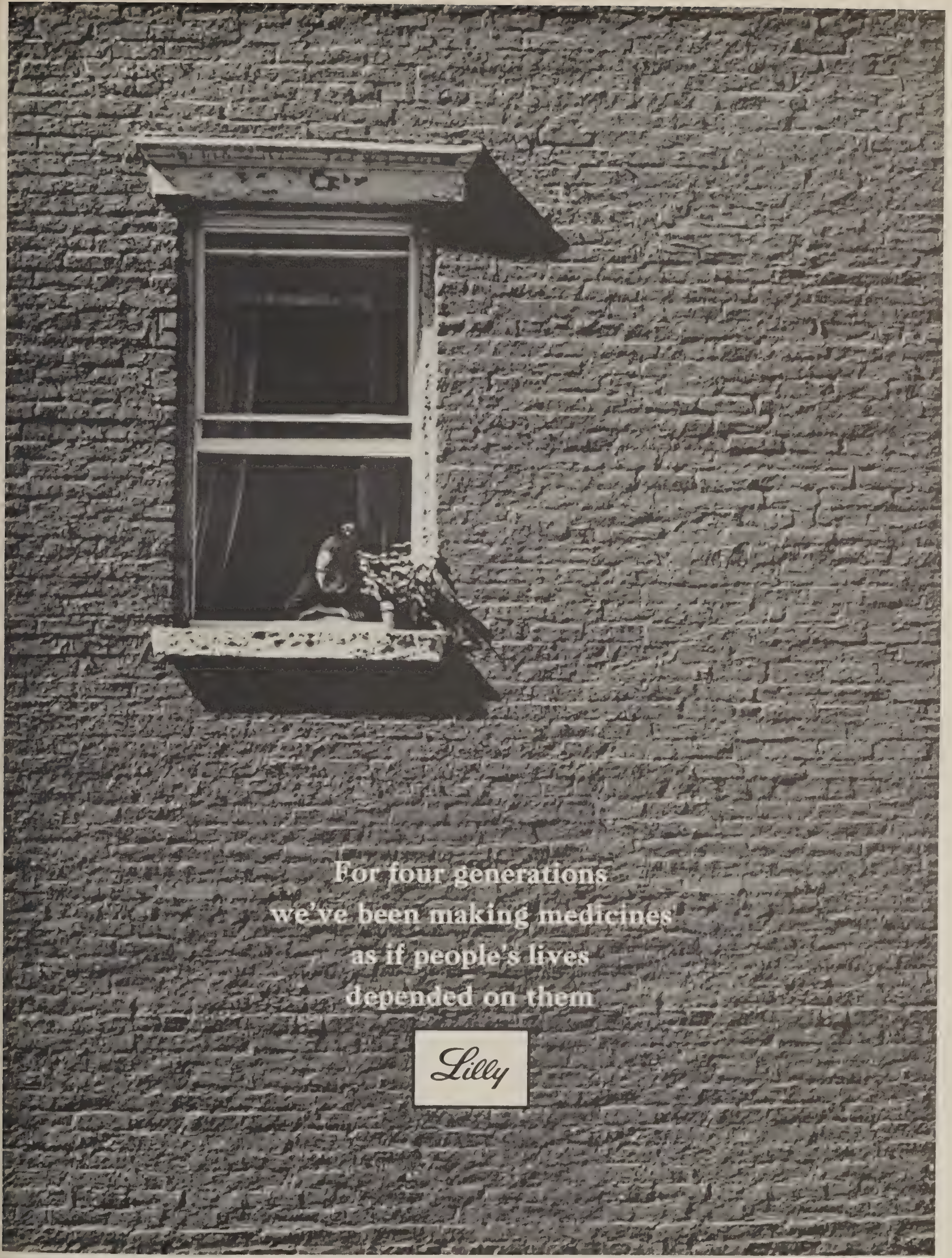

For four generations
we've been making medicines
as if people's lives
depended on them
Lilly

This advertisement is one of a series appearing in *Time*, *Life*, *Today's Health*, and *Saturday Review*.

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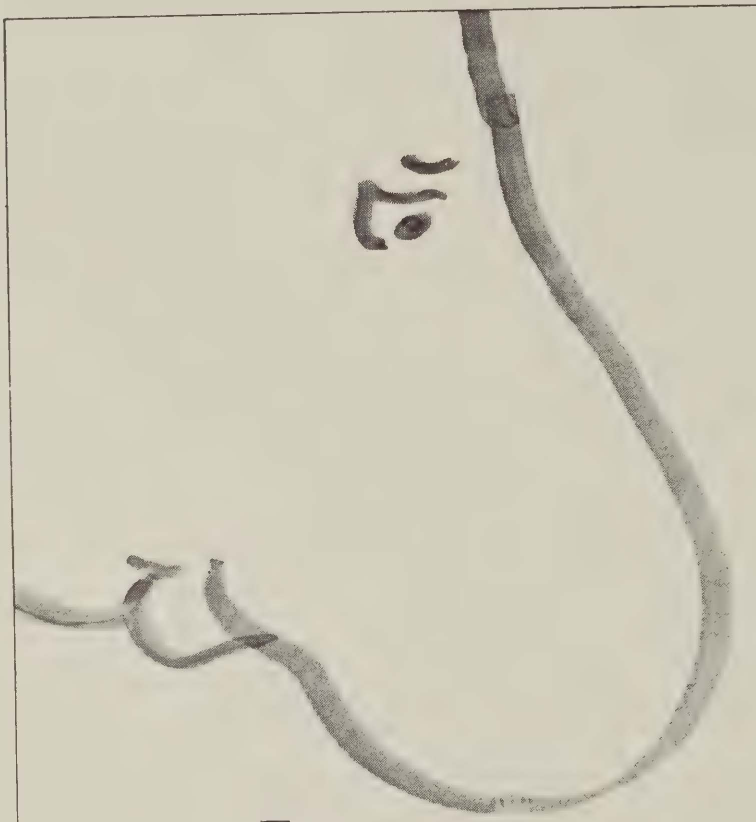

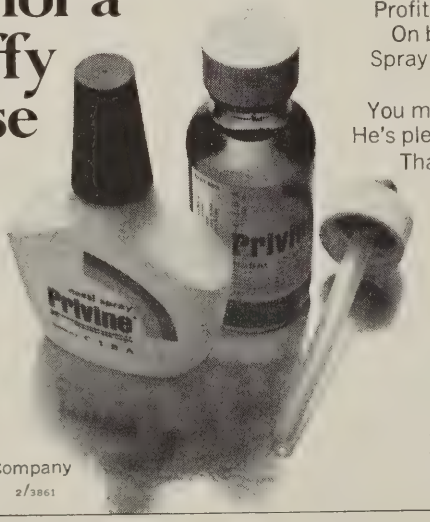

Fast company for a stuffy nose

Privine can move fast because it works fast. In summer—for allergy ... in winter—for colds. Year round.

Profit margin? It's tops. On both Privine Nasal Spray and Privine Nasal Solution.

You make a good friend. He's pleased with Privine. That's as clear as the nose on his face.

Privine®
hydrochloride
(naphazoline
hydrochloride)

C I B A

CIBA Pharmaceutical Company
Summit, New Jersey 2/3861

The Maryland Pharmacist

NATHAN I. GRUZ, *Editor*

650 WEST LOMBARD STREET
BALTIMORE, MARYLAND 21201

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SPEA
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VOLUME 45 JUNE 1969 NUMBER 6

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Editorial . . .

DIRECT PHYSICIAN-PHARMACIST TELEPHONE LINES

Physicians and pharmacists must, of course, work closely together in order to provide the best possible health care for their patients. Traditionally it is the prescription order form which, to the patient, is the concrete demonstration that his physician has conscientiously examined and diagnosed the case. The medication dispensed by the pharmacist pursuant to the prescriber's prescription order is the tangible evidence to the patient (and the physician's peers) that the doctor has on the basis of scientific and professional judgment selected the therapeutic regimen most appropriate under the circumstances.

For some time past and continuing under contemporary conditions, it is frequently necessary for physicians to prescribe by telephone rather than by means of a written prescription order. This may be motivated by the desirability or necessity for expediting the delivery of medication, by an emergency situation or for convenience. The prevailing practice of telephoning prescription orders is also recognized by references and authorization in various drug laws, such as for Class B narcotics and other legend drugs.

Unfortunately, however, a practice developed whereby direct telephones were established between a physician's office and one particular pharmacy. This situation often resulted in the physician, with this arrangement, telephoning all or most of his prescription orders to one pharmacy. As this was usually done without consultation with, or the consent of the patient, the result was *eliminating freedom of choice of pharmacy* to the patient.

The cost of the telephone installation and the monthly service charge and expense has always—as far as we know—been borne solely by the sponsoring pharmacy. In effect, this assumption by a pharmacist of a physician's expense for telephoning oral prescription orders is a form of subsidy or rebate, which is an unethical or unprofessional act.

In spite of the convenience (or benefits of any kind or degree which may be derived by physician, patient or pharmacist) many allegations as to possible collusion over the years have raised suspicions regarding the motivation of the pharmacists and the physicians linked by direct telephones. Revelations of abuse in the Medicaid Program involving direct telephone lines have only highlighted a situation that most pharmacists have felt to be untenable on ethical grounds.

Maryland Board of Pharmacy News . . .

Pharmacy Changes . . .

The following are pharmacy changes for the month of June:

New Pharmacies

Drug Fair No. 131, Milton L. Elsberg, President, 1050 Industrial Blvd., Cumberland, Maryland 21502.

Greenbelt Professional Pharmacy, Murry Gellman, President, 6201 Greenbelt Road M-9, College Park, Maryland 20740.

White Cross, D. M. Robinson, President, 913 Taylor Ave., Loch Raven Plaza, Towson, Maryland 21204.

Change of Ownership, etc.

Rex Drugs, Inc., Leon Rosen, President, 4637 York Road, Baltimore, Md. 21212, (Formerly I. J. Hendelberg, President).

No Longer Operating as Pharmacies

S. Klein Pharmacy, Joseph Walker, President, 6000 Greenbelt Road, Greenbelt, Maryland 20770.

The Maryland Pharmaceutical Association has long been concerned about this issue and has made it a subject of discussion in the Pharmacy Liaison Sub-committee of th Medical and Chirurgical Faculty (State Medical Society) which is composed of representatives of the two groups. O the basis of its recommendations, "Med-Chi" and MPhA have now both agreed that *direct telephone lines betwee physicians and pharmacists are unethical and must b terminated.*

Physicians and pharmacists have now been put on notic that direct telephone lines are unethical and existing i stallations should be removed. Failure to comply will su ject both parties to appropriate disciplinary action.

Physicians will, of course, still be able to call prescri tion orders through regular telephone lines to the pharma of their patient's choice.

We believe termination of this practice will eliminate source of friction and suspicion. This action will furth the establishment and maintenance of the confidence of t public in the integrity of both professions.

The Environment of Excellence

By Charles B. Thornton

Chairman of the Board
Litton Industries/Beverly Hills, California

This is the most dynamic, challenging era ever experienced by modern business. Our progress, encompassing all phases of industrial endeavor, dwarfs the accomplishments of the past; our prospects for continuing growth in the future—and for achieving a true environment of excellence—are limited only by the boundaries of our collective imaginations.

The future will be spurred by a national population expected to increase more than one and one-half times by the end of the century. It will be a younger and better educated population, and determined to gain its material dreams while developing the benefits of leisure time to the fullest.

The people who succeed in this future—particularly young adults—will recognize the discipline of savings as a vital attribute to family security. Many will wisely learn the lesson of regular thrift through the U.S. Payroll Savings Plan.

Their purchases of Savings Bonds and Freedom Shares will help finance educations, homes, children, travel and other essentials of the good life.

We in American industry look forward to sharing with this new and energetic population the challenges, the responsibilities and the opportunities of our dynamic future; to building with them the environment of excellence that the times demand.

Congressman Advises on Writing to Legislators

Next time you heed the urgent "Write your Congressman today," capitalize on these tips from a man at the receiving end—Rep. Peter H. B. Frelinghuysen (Rep., N.J.). He advised constituents to keep the following points in mind when communicating with "the Hill."

- A letter beats a phone call, because it constitutes a written record and requires a written reply. Reaching him by telephone is difficult, because he spends so much time in sessions and at committee meetings. But he reads and initials almost every piece of mail.
- Confine your letter to one or two pages, and make sure that name and address are legible.
- Focus on one subject. A letter which includes a variety of topics invites a general reply.
- Give reasons for the position you take. Those affected by the law often know more than Congressmen do about its practical effect.
- Don't resort to promises or threats. Both are offensive and self-defeating.
- A personal letter is better than a form letter or petition. Even if rewritten, form letters are recognizable and generally evoke a form response.
- Write to your own legislators. Congressional courtesy requires that letters received by a Congressman from people outside his district be referred to the Congressman from the writer's district.

NIH Institute on Environment

The establishment of the National Institute of Environmental Health Sciences this year reflects the increasing public attention being paid to the hazards of health around man.

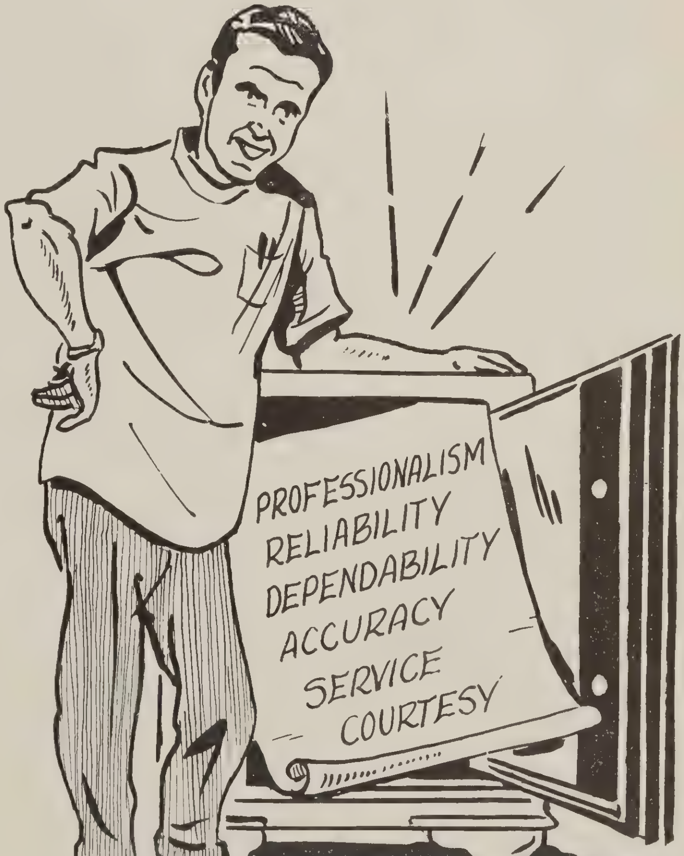
The Institute will study the health hazards in man's environment in order to forstall them by singling out the hazards to health.

The new Institute will be located at Research Triangle Park, N.C. and will be the only major part of NIH not located in Bethesda, Maryland. The director is Dr. Paul Kotin.

Scientists are working at the Institute's North Carolina research center to identify harmful agents in the environment and to find out how they affect people's lives.

When you meet a man without a smile, give him one of yours.

A business is like an automobile: the only way it can run by itself is downhill.



THE PHARMACIST'S VALUABLE ASSETS

Some Notes of Thanks . . .

Welcome Excerpts From Letters

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE
HOSPITAL ASSOCIATION
BALTIMORE, MARYLAND

Dear Mr. Gruz:

It was no small pleasure to have been associated with you in the preparation of the hospital pharmacy guidelines.

The purpose of this short note is to express thanks and appreciation for your cooperation and able assistance in this endeavor.

I am sure we will have a document of which all of us will be proud to say we played a part in its production. There is no doubt in my mind as to its importance as a contribution to the health field in which all of us work.

Thanks again to you and your organization.

Sincerely yours,
/s/ Charles E. Burbridge
President-elect

GREATER BALTIMORE CHAPTER
THE NATIONAL FOUNDATION
MARCH OF DIMES

Dear Mr. Gruz:

I would like to take this opportunity to thank you and the Maryland Pharmaceutical Association for your cooperation in the distribution of the March of Dimes display, "Prevent Birth Defects." The results of the mailing have been most satisfying and will certainly assist the March of Dimes in transmitting to the general public the importance of proper prenatal care and the magnitude of the problem of birth defects.

Sincerely yours,
/s/ James F. Donovan
Executive Director

IF YOU WANT TO GIVE UP CIGARETTES

If you want to give up cigarettes, the American Cancer Society has a new pamphlet to help you.

According to Dr. Elliott Michelson, president of the Society's Maryland Division, the pamphlet, "If You Want to Give Up Cigarettes," brings together a variety of suggestions and tips that may be useful in helping individuals stop cigarette smoking. Designed to approach the problem of giving up cigarettes in a quiet, no-nonsense method, the pamphlet points out that each individual must face the problem in his own way.

Dr. Michelson said that the pamphlet grew out of an American Cancer Society Conference of physicians, psychologists and educators interested in helping smokers break the habit. The suggestions for stopping the cigarette habit have been collected from experimental projects that have been carefully evaluated, he said.

No sure techniques are offered, he pointed out, and no absolute laws of human behavior are provided. "There are different kinds of smokers and what helps one, it is shown, may not work for another. Individuals must choose for themselves from what is presented in the pamphlet."

Several actual case histories are given, which serve to highlight the fact that there are some 21 million ex-cigarette smokers today in the United States. "You can kick the habit," the pamphlet insists. "The great sense of satisfaction, the tremendous pride in being able to do without cigarette smoking is very rewarding to the ego—and to the ego's mate."

Included are various suggestions as to what actions can be taken to fill the gap once the no-smoking step has been experienced. The ACS pamphlet also offers sound advice on how to handle the difficult withdrawal period. How to react to failure is also discussed sympathetically.

Cigarette smokers who want to try and stop the habi can get a free copy of "If You Want to Give Up Cigarettes," by writing the American Cancer Society, Box 9822, Balti more, Maryland 21204.

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CHANGE OF ADDRESS

When you move—

Please inform this office four weeks in advance to avoid undelivered issues.

"The Maryland Pharmacist" is not forwarded by the Post Office when you move.

To insure delivery of "The Maryland Pharmacist" and all mail, kindly notify the office when you plan to move and state the effective date.

Thank you for your cooperation.

Nathan I. Gruz, Editor
Maryland Pharmacist
650 West Lombard Street
Baltimore, Maryland 21201

We used to make gold-plated pills

We did from 1913 into the mid-Twenties. They were rolled on this gold leaf to pick up a fine golden luster.

We don't do it now.

Today, we concentrate on putting the quality on the inside, where you and the doctor and the patient want it.

The name Upjohn is on the outside.

That says it just as well.

Upjohn

© 1969, The Upjohn Company, Kalamazoo, Michigan

SMA
INFANT FORMULA

Mother's big helper. S M A® Ready-to-Feed by the quart.

Stock now for increased profits and faster turnover.

Be ready for customer demands generated and sustained by traffic-building, heavy promotion from Wyeth.

New, quart-size S M A Ready-to-Feed is being featured in full-color, multi-page consumer ads to new and expectant mothers. And the physicians these mothers consult are being reached by medical-journal ads, direct mail and detailing.

Ready-to-Feed S M A infant formula nourishes like mother's milk. A whole day's feeding... premixed, presterilized.

Available through your Wyeth servicing branch ($50 minimum order)

1-9 cases, per case of 12:	$6.12
10* cases or more, each:	$5.95

*May be assorted with other S M A products.

Wyeth Laboratories Wyeth Philadelphia, Pa.

30
CONTAC
6
NORTH
Cooper

Grab the Big One!

When it comes to a cold product, Contac is —the brand most people think of —the brand most people buy.

And pharmacy's fastest-moving proprietary is setting new sales records every year. Sales were up 19% last winter—leading the rest of the market.

Plan to move Contac at record-breaking speed. Day in, day out, Contac is presold with more advertising than any other cold product. And all Contac ads net more customers for pharmacy.

Now, at the height of the cold season, snowball profits with the Contac Last Chance Gold Medal Deal.

But hurry, the Deal ends Feb. 22. Figure an order that will cover you through summer colds and allergies and zip it in today.

CONTAC® LAST CHANCE GOLD MEDAL DEAL

MENLEY & JAMES LABORATORIES, Philadelphia, Pa. 19101

Handling Professional Samples

by Charles S. Bender, Inspector

Baltimore District
Food and Drug Administration

The objective of the "FDA Workshop Program for Dispensing Pharmacists" is to attempt to eliminate some of the problems practicing pharmacists face in complying with FDA and other governmenal agencies regulating the pharmaceutical industry. One of these problems is the redistribution of physician samples through salvage dealers, drug repackers, charitable organizations, hospitals and retail pharmacies. FDA's contact with the pharmaceutical industry is rather broad in that inspections cover not only the basic pharmaceutical community but church groups and charitable organizations collecting professional samples for redistribution to overseas stations. We have noted an ever increasing interest in the collection of professional samples by church groups redistributing drugs to foreign missions. The retail pharmacists may be indirectly affected by charitable group programs as physicians and pharmacists have been asked to participate in supplying drugs and monitoring collection programs.

FDA Policy on Samples

FDA, the pharmaceutical industry, physicians and pharmacists are in agreement that the distribution of professional samples to the physician is an acceptable method for promoting drugs. We have no reason to dispute the claim that professional samples afford the physician the opportunity to evaluate the merits of various drugs and provide needed medication to indigent patients. FDA *has* raised objections to the possession, sale and dispensing of physician samples by persons other than registered physicians. We have noted continued handling of professional samples by individuals in groups other than the practicing physician. The groups currently dealing in physician samples have been noted as follows:

1) Salvage Dealers
2) Drug Repackers
3) Hospital Pharmacies
4) Retail Pharmacies
5) Charitable Organizations

In view of the fact that the program is directed to the dispensing pharmacist, it is necessary that we establish FDA's policy regarding the handling of professional samples by the pharmacist. FDA's policy is clearly established under Civil Action No. 61 C 1361, United States District Court, Northern District of Illinois vs. Keefer's Pharmacy, Mount Prospect, of prescription legend drugs, claimed by J. T. Keefer and whose labels bore the legends, 'Sample: Not to be Sold,' 'Professional Sample—Not to be Sold,' 'Physician's Sample,' etc. and similar wording were manufactured and packaged to be distributed by the manufacturers only to physicians and clinics, to be used by the physician and clinics so that they could become familiar with the effects of the drugs on their patients. These drugs were not manufactured to be distributed to pharmacists and others to be sold in the ordinary course of their business." Conclusions of law further summarized that "Those various articles of drugs whose labels bore the legend, caution: Federal law prohibits dispensing without prescription," and "Sample: Not to be Sold," "Professional Samples Not to be Sold," "Physician's Sample," and similar wording, are misbranded while held for sale after shipment in interstate commerce within the meaning of the Act 21 U. S. C. 352(a) in that the words "Sample: Not to be Sold," "Professional Sample—Not to be Sold," "Physician's Sample," and similar wording on the labels of said articles are false and misleading in that they were held for sale in the ordinary course of business by J. T. Keefer, Keefer's Pharmacy at 10 East Northwest Highway, Mount Prospect, Illinois.

Compliance With New Regulations

In addition to the previously mentioned misbranding the pharmacist handling physician samples may also find difficulty in complying with current new drug, antibiotic and drug abuse regulations. Some of the problems concerned with maintaining the integrity, safety and control over potent drugs may be noted as follows:

1. Drug recalls involving professional samples found to be sub-potent, cross contaminated with penicillin, etc. many not be directed to the pharmacist because the manufacturer's records do not show the redistribution beyond the physician level.

2. Professional samples containing drugs subject to current drug abuse regulations must be accounted for on required inventory records.

3. Product integrity may be lost where 1 to 100 small lots are combined in a stock container maintained in the retail pharmacy.

4. Retail pharmacies engaged in repacking operations are required to register and to establish adequate controls in compliance with current Good Manufacturing Practices Regulations.

5. Full disclosure information that includes warnings, contra-indications, directions for use, etc. may be destroyed or nonexistent on loose samples collected from physicians.

6. Old and outdated products suspect of deterioratio may be inadvertently dispensed if labeling and/or inspection is inadequate.

7. New drugs and antibiotics may not be repacked o relabeled without FDA approval. Repackers of new drug are required to obtain supplemental approval from Nev Drug Branch, while repackers of antibiotics must obtai recertification for repacked antibiotics.

The previously named trouble areas are only a few o the problems that confront the pharmacist when professional samples are handled, repacked and dispensed. FD intends to continue its investigation of those persons repacking physician samples in an effort to eliminate th sale of deteriorated, outdated and otherwise misbrande drugs found to be potentially dangerous to the health c the consumer. We have been advised that H.R. 13885 Dru Safety Act of 1966 introduced to the House of Represent tives on March 22, 1966 may serve to control the probler of sample drugs in a manner acceptable to FDA and reg lated industry.

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*Adapted from a presentation at FDA Workshop for Dispensing Pharm cists jointly sponsored by Maryland Pharmaceutical Association, Ur versity of Maryland School of Pharmacy, Maryland Board of Pharmac and Baltimore District of the FDA.

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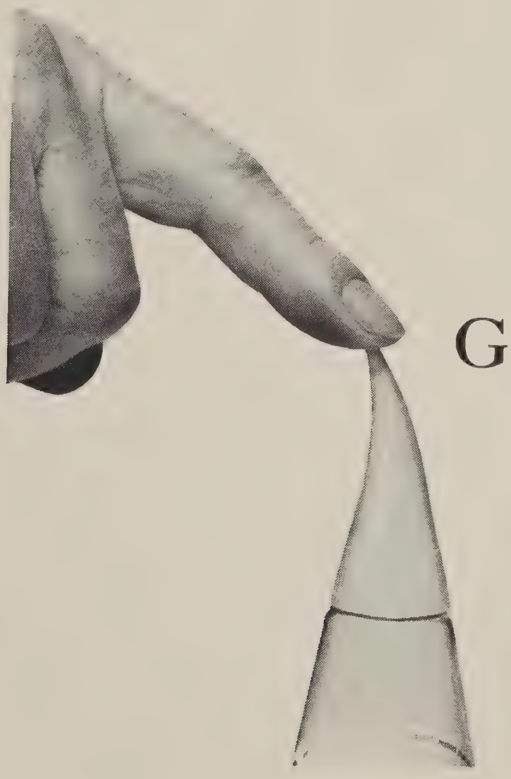

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Authorization of Refills

by Merl J. Ryan, Food and Drug Officer

Baltimore District Food and Drug Administration

We have no arbitrary authority under the provisions of the Federal Food, Drug, and Cosmetic Act to determine what drugs must be restricted to prescription sale; however, Section 503(b) of the Durham-Humphrey Amendment does require three kinds of drugs to be labeled with the prescription legend:

1) Habit-forming drugs as described in Section 502(d) of the Act: narcotics, hypnotic substances, and etc.;
2) Drugs which are not safe for use except under the supervision of a practitioner licensed by law to administer such drugs;
3) Drugs limited by approved new drug applications to use under the professional supervision of a licensed practitioner.

Licensed Under State Law

You also know that physicians and pharmacists are licensed under State law and not by a Federal agency. The Food, Drug, and Cosmetic Act does not give us the authority to control the practice of medicine. The primary purpose of the Durham-Humphrey Amendment is to insure that the patient gets the precise drug which the physician wishes the patient to have for treating his illness. If the patient has not been previously exposed to a drug, it is important that the physician closely supervise the consumption of the drug. The physician, prior to prescribing a drug, has inquired about the hypersensitivities, general and specific, and even in their absence, may prescribe only a small dose. This is doubly important in a new drug or one that has been on the market less than one or two years.

Section 503(b)(1) of the Food, Drug, and Cosmetic Act, the Durham-Humphrey Amendment which I previously mentioned, specifies that the drugs that fall into the abovementioned three categories shall be dispensed only:

1) Upon a written prescription of a practitioner licensed by law to administer such drug;
2) Upon an oral prescription of such practitioner which is reduced promptly to writing and filled by the pharmacist, or
3) By refilling any such written or oral prescription if such refilling is authorized by the prescriber, either in the original prescription, or by oral order which is reduced promptly to writing and filed by the pharmacist. The act of dispensing a drug contrary to the provisions of this paragraph shall be deemed to be an act which results in the drug being misbranded while held for sale.

That section of the Act also requires that the label on the dispensing container contain the name and address of the dispenser, the serial number and date of the prescription or of its filling, the name of the prescriber and, if stated in the prescription, the name of the patient, and the directions for use and cautionary statements, if any, contained in such prescription.

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*Adapted from a presentation at FDA Workshop for Dispensing Pharmacists jointly sponsored by Maryland Pharmaceutical Association, University of Maryland School of Pharmacy, Maryland Board of Pharmacy, and Baltimore District of the FDA.

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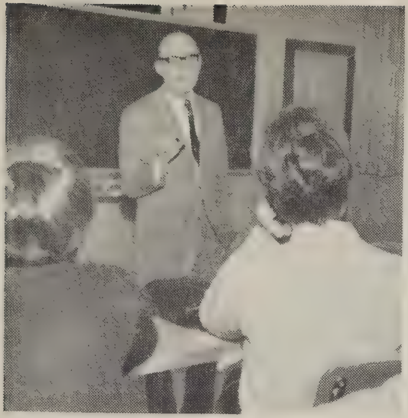
David Perelman and University of California Student Group Win APhA Public Education Awards

Pfizer Laboratories sponsor of competition

The Winner's Trophy

Montreal, Canada, May 17-23, 1969: David Perelman, a community pharmacist of Pittsburgh, Pa., and the Drug Information Committee of the APhA-CPhA Student Chapter at the School of Pharmacy, University of California, San Francisco, were named winners of the 1968 APhA Public Education Awards Competition, sponsored by Pfizer Laboratories. Presentations were made at the APhA annual meeting in Montreal, where the winning entries were on exhibit.

Now in their eighth year, the PEAC awards are regarded as among the highest in pharmacy. They are presented to an individual pharmacist and to a pharmaceutical organization whose work during the year has been considered most effective in educating the public to pharmacy's role in promoting community health. They consist of a trophy, a cash prize of $500.00, and an expense-paid trip to the APhA annual meeting.



Mr. Perelman makes a point during a Pittsburgh lecture on drug abuse.

University of California students and faculty members discuss their winning entry. From left to right (sitting): J. Harris Fleming, Director of Trade Relations for Pfizer Laboratories Division; Diane Rheuark; Max W. Eggleston, President of the APhA; Dr. Jere E. Goyan, Dean of the School of Pharmacy, University of California; (standing) Dr. Robert L. Day; David S. Adler; Raymond L. Sattler; and Luann K. Dodini.

Mr. Perelman (center) is flanked by Max W. Eggleston, APhA; and J. Harris Fleming, Pfizer Laboratories Division in the compounding department at his pharmacy.

Helped Educate Public on Drug Abuse

Both of the winning entries sought to educate the public on the problems and dangers of drug abuse. Mr. Perelman delivered an "honest and intelligent presentation" on drug abuse in a variety of ways.

He made television and radio appearances, spoke to lay and professional groups, and delivered his message in newspaper articles and advertisements.

The University of California students desired "to create an attitude in the general public of an intelligent respect for drugs rather than an ignorant fear." Thus, they called their group Drug Information Committee rather than Drug Abuse Committee. The students were given special training and presented dialogue programs to junior and senior high school students and professional and lay groups.

The Golden Gate Bridge backdrops J. Harris Fleming, Pfizer Laboratories Division; Dean Jere E. Goyan, and Dave S. Adler, University of California; Max W. Eggleston, APhA; Daniel E. Furtado, University of California; as Californians are honored for their winning entry.

Judges of Competition

Members of the APhA Public Relations Committee served as judges, with the assistance of Donald B. McCammond of Connecticut, vice president of the Public Relations Society of America. They were Chairman William L. Long of Indiana, Donald W. Arthur of New York, William J. Bowen of Pennsylvania, Edward S. Brady of California, and J. Harris Fleming of New York.

Send for entry blank for 1969 PEAC Awards. Presentation scheduled for the Washington meeting.

You may enter yourself or nominate some other person or organization. A brochure outlining the rules for prospective entrants and entry blanks are available from:

Public Education Awards Competition, American Pharmaceutical Association, 2215 Constitution Avenue, N.W., Washington, D.C. 20037.

Deadline for all entries is December 31, 1969. Awards will be made and winning entries displayed at the 1970 APhA Annual Meeting in Washington, D.C.

Ophthalmic Therapy — Then and Now

Samuel L. Fox, M.D.*

Presented at the Ninth Annual Robert L. Swain Pharmacy Seminar on March 20, 1969, Holiday Inn-Downtown, Baltimore by the Maryland Pharmaceutical Association in conjunction with the University of Maryland School of Pharmacy.

It is indeed a genuine pleasure for me to be on the program of the Robert L. Swain Pharmacy Seminar. I had the privilege of knowing Dr. Swain well. In the years immediately following the publication of the U.S.P. XI and N. F. VI he encouraged me to write a lengthy series of articles for publication in *The Maryland Pharmacist* in which I attempted to explain for the student and the practicing pharmacist the many changes which had been effected in these newly revised standards. Subsequently, Dr. Swain obtained sponsorship for the publication of these articles as a small reference book, and he was instrumental in having the National Association of State Boards of Pharmacy adopt this book as its standard for examinations in Galenical Pharmacy. Tonight I have two rare opportunities: first, to step back into the same role of attempting to bring students and practicing pharmacists up to date in ophthalmic therapy; and secondly, I have the very real privilege of paying homage to a great leader of American Pharmacy whose friendship and benefactions I enjoyed and whom we honor by this Seminar.

The title of my presentation tonight was chosen with deliberation. So many changes have occurred in medical and pharmaceutical practice in the last decade that one often loses sight of the pioneering work which preceded our present era of practice. Ophthalmic therapy has been in the forefront of this rapid and multifarious state of flux. The older I become the more I realize that one needs a background of the history of the past to properly understand the present, and hopefully the future, in any field of endeavor. The best known restored city in America is Williamsburg, Virginia. The Williamsburg Restoration has wisely chosen as its motto, "That the future may learn from the past." And so, we shall review the past as a prologue to the present era of therapy, and I trust we shall go away better prepared to cope with the changes which tomorrow is sure to bring.

Purposes of Therapy

All therapy is directed at the eradication of pathology and the restoration of function of the affected parts. Specifically, ocular therapy may be classified under four categories:

1. Agents for the relief of pain
2. Anti-inflammatory agents
3. Anti-infectious agents
4. Agents for special purposes

We shall attempt to review briefly the common drugs of the past and of the present in each of these categories. In this connection, I have searched through my collection of historic old medical books for some representative samples of eye prescriptions through the ages.

1. Agents for the Relief of Pain

Many ocular conditions are associated with moderate to severe pain. This is true of external ocular pathology (such as corneal abrasions and erosions, foreign bodies, burns, ulcers and other such inflammations), as well as intra-ocular disease such as iritis and iridocyclitis, glaucoma, endophthalmitis and trauma. In all such instances opthalmologists have sought means of relieving the pain while treating the basic pathology. Such means have not always been available, however.

a. Local Anesthetics:

It is interesting to recall that cocaine alkaloid was first isolated from the leaves of *Erythroxylon coca* by Niemann in 1860. The plant had previously been introduced into Europe as a botanical curiosity in the 16th century after the Spanish, led by Pizarro, conquered Peru and found that the aboriginal Indians had been chewing the leaves of the coca plant for many centuries to relieve fatigue. Some 24 years after Niemann isolated cocaine from the plant Sigmund Freud requested and obtained a sample of the cocaine alkaloid from the Merck Company for the purpose of trying it on a young physiologist who had become addicted to opium and who had placed himself under Freud's care for treatment. Freud discovered that the drug "had a somewhat bitter taste and exerted a numbing influence on the gustatory nerves, so that they became almost completely insensitive." He engaged his friend, Carl Koller, a prominent surgeon, to test the anesthetic effects of the new drug Koller tested cocaine in the eyes of frogs and guinea pigs then in his own eyes and those of several of his colleagues He observed the potent local anesthetic effect. Freud later stated,

> "Koller can be rightfully considered the discoverer of local anesthesia with cocaine, which has been so important in minor surgery."

As a matter of interest to us in Baltimore, Halstead at th Johns Hopkins Hospital in 1885 demonstrated that cocain could be used to produce a nerve block.

How was local pain in the eye treated before cocaine became available? In 1838 Benjamin Ellis, M.D., Professor of Materia Medica and Pharmacy in the Philadelphia Colleg of Pharmacy, published *The Medical Formulary*, a compendium described on the title page as "A collection of prescriptions, derived from the writings and practice of many of the most eminent physicians in America an Europe." In it we find a number of collyria for the relie of pain in the eye. It is interesting to read the definitio given by Dr. Ellis for the term "collyria:"

> "These are preparations applied to the eyes; they are sometimes dry, but generally liquid—consisting of infusions, decoctions, or distilled water, with the addition of various substances."

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* Dr. Fox is a graduate of the School of Pharmacy, University of Maryland ('34). He holds the ranks of Associate Professor of Ophthalmology and Assistant Professor of Pharmacology in the School of Medicine, University of Maryland, and he is Director of the Department of Ophthalmology at the South Baltimore General Hospital.

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   Camphorae, gr. v
   Mucilaginis Acaciae, ℥ j
   Misce, et fiat collyrium.

2. *Dry Collyrium of Opium*

   Rx

   Pulveris Opii, gr. iv
   Calomelanos,
   Sacchari purificati, aa. ℈ j
   Tere bene.

   Dr. Ellis's comment: "These compounds are blown into the eyes for removal of specks on the cornea occasioned by inflammation."

3. *Collyrium of Acetate of Ammonia with Opium*

   Rx

   Liquoris Ammoniae acetatis, ℥ ij
   Aquae ferventis, ℥ vj
   Extracti Opii mollis, gr. x

   Dissolve the extract of Opium in the hot water—strain, and add the liquor of acetate of ammonia. Dr. Ellis's comment: "Useful in acute ophthalmia when there is considerable pain after depletion."

It is now known with certainty that opium and its alkaloids exert no local anodyne effect. Any beneficial results obtained by the use of opium locally is due to the absorption of the drug through broken skin or mucous membrane. Krantz and Carr in their textbook, *Pharmacological Principles of Medical Practice,* categorically state, "The local application of opium is based upon a false premise and today must be considered beyond the pale of rational therapeutics." (I would point out that the current editions of the U.S.P. and N.F. no longer include such preparations as the formerly popular suppositories of opium and belladonna.)

When one reviews prescriptions such as these it is easy to agree with Voltaire (1694-1778), who said:

> "Doctors are men who prescribe medicines of which they know little, to cure diseases of which they know less, in human beings of whom they know nothing."

Thus, the chemical isolation of cocaine alkaloid opened an entirely new vista of ocular therapy and made possible modern ocular surgery. However, cocaine soon proved to be less than the ideal drug for use in the eye, since it was both toxic and habit-forming. The solution hydrolyzes quickly so that the concentration of cocaine reduces itself day by day and the preparation becomes more and more acid. As the pH value becomes lowered the solution rapidly loses its effectiveness as a local anesthetic and becomes a severe irritant to ocular tissues. Solutions are required to be made fresh daily, therefore. In addition, cocaine solutions make a fine culture medium for both bacteria and molds, and soon become infected with both. Iatrogenic infections after use of cocaine, often with loss of the eye, were common. Later it was found that cocaine solutions are harmful to the corneal epithelium so that repeated applications of the drug soon leads to corneal erosions as a serious complication.

The matter of contamination of the solutions by bacteria and molds has been partially resolved by the addition of sufficient benzalkonium chloride (Zephiran^{R}) to make a 0.01% solution of this detergent agent, or by the addition of sufficient chlorobutanol to provide a 0.15% solution of this agent. Cocaine solutions find very limited usefulness in modern ophthalmology. When requested to prepare such a solution, however, you should seek permission to add a preservative, the solution should be prepared under aseptic conditions, it should be placed in small dark brown bottles, and a label should be attached warning that the solution should be kept in a cool place away from light.

After the synthesis of cocaine was accomplished in 1902 by Willstatter, a host of synthetic analogues quickly followed in an effort to produce a more satisfactory local anesthetic preparation. In 1905 procaine (Novocaine^{R}) was synthesized and this drug still enjoys wide popularity for nerve block and spinal anesthesia. Unfortunately, procaine exerts no anesthetic effect when applied topically.

Many additional local anesthetic drugs have appeared (Butyn^{R}, Metycaine^{R}, Holocaine^{R}), but for the most par they now enjoy little or no usuage in ophthalmology. A the present time, the two most widely used local anesthetic preparations for topical use in the eye are proparacain (Ophthaine^{R}, Ophthetic^{R}) and tetracaine (Pontocaine^{R}) These drugs are effective local anesthetics when applie topically to the eye and they exert the least adverse effect upon the corneal epithelium. Because of the harmful effect which all topically applied local anesthetics have on th corneal apithelium, local anesthetic preparations should b applied only by a physician and none should be prescribe for use by the patient himself.

Tetracaine solutions have the advantage of chemical sta bility over long periods of time. They have an indefinit shelf life and do not require refrigeration after the pack age is opened. Proparacaine solutions have a short shel life and must be refrigerated after the package is opene in order to retain their effectiveness for even a week o two. As soon as the solution takes on a straw-colored ap pearance, it should be discarded.

For injectable use for nerve block anesthesia in eye su gery, procaine and lidocaine (Xylocaine^{R}) enjoy wid popularity among ophthalmologists at the present tim Both solutions are stable and must be sterile. They ar usually dispensed in sterile ampuls.

b. *Systemic Narcotic Analgesics*:

The use of opium for the relief of pain pre-dates r corded history. The first undisputed reference to poppy jui as a drug is found in the writings of Theophrastus in th third century B.C. The power of opium to relieve pain mentioned in the Papyrus Ebers and in the writings Galen. Paracelsus carried a piece of opium in the pomm of his sword. He named the extractive tincture of opiu *laudanum*, from the Latin *laudo, I praise.* Opium is thoug to be the *gall* referred to in the *New Testament* which th Daughters of Jerusalem gave to Jesus in his last momen on the cross to relieve his agony. In 1680 Sydenham wro

> "Among the remedies which it pleased Almighty God give to man to relieve his sufferings, none is so u versal and so efficacious as opium."

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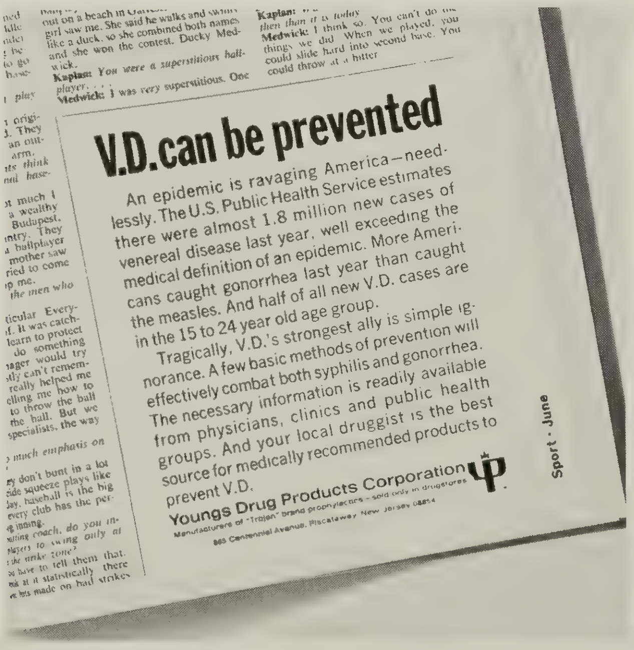

V.D. can be prevented

An epidemic is ravaging America—needlessly. The U.S. Public Health Service estimates there were almost 1.8 million new cases of venereal disease last year, well exceeding the medical definition of an epidemic. More Americans caught gonorrhea last year than caught the measles. And half of all new V.D. cases are in the 15 to 24 year old age group.

Tragically, V.D.'s strongest ally is simple ignorance. A few basic methods of prevention will effectively combat both syphilis and gonorrhea. The necessary information is readily available from physicians, clinics and public health groups. And your local druggist is the best source for medically recommended products to prevent V.D.

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Because he prescribed opium so often, the English physician came to be known as Doctor Opiatus.

And so opium and its various preparations came also to be used in ophthalmology for the relief of painful ocular conditions. Unfortunately, opium and its alkaloids, as a rule, produce severe miosis, or constriction of the pupil, and this is frequently an undesirable side-effect which may prove harmful for the eye in its pathologic state. There is one ocular condition for which the use of opium or morphine is ideal. In acute glaucoma, where the pain is intense, a large dose of morphine serves the dual purpose of providing almost immediate relief from pain and at the same time assisting in the production of a desired miosis. Another undesirable and often harmful side-effect of morphine and opium in eye patients is nausea and vomiting. This is especially undesirable and dangerous after ocular surgery and may result in complete loss of vision in the eye. In modern practice, therefore, the use of milder narcotic-analgesics such as meperidine (Demerol^R), especially in combination with sedative tranquilizers, has practically replaced the use of opium and morphine, except in the rare case of acute glaucoma.

The use of anti-nauseant drugs is common in hospitalized eye patients before and after surgery upon the eye. Most of these compounds are either phenothiazine tranquilizers or sedative antihistaminics. It is important that the ophthalmologist be aware of all similar drugs which the patient may have taken just prior to hospitalization, as such drugs may cause a dangerous fall in blood pressure if a cumulative effect is attained. Recently the non-phenothiazine, hydroxyzine pamoate (Vistaril^R), has enjoyed increasing popularity as a sedative-tranquilizer anti-nauseant agent before and after ocular surgery. It appears not to affect the blood pressure. It should be kept in mind that tranquilizers usually potentiate the narcotic-analgesic agents, and reduced dosage of each is indicated when combined usage is desirable. If full doses of each drug are used, severe respiratory depression may occur with fatal results.

2. Anti-Inflammatory Agents

It has long been recognized that the eye is subject to numerous inflammatory diseases which are not associated with infection. In all cases of inflammation the use of heat pplied locally is as old a remedy as medicine itself, and he eye has been no exception to the rule. The use of lasters and other heat-retaining "antiphlogistic" salves, hough very popular generally, did not find great useful- ess in ophthalmology because of the irritation which in- ariably resulted in the eye from contact with such agents. However, before the advent of the electric heating pad, the lectrically heated compress stove, and the infra-red lamp, moulded rubber eyepads containing colloidal gels were marketed in an effort to supply heat to the eye for pro- onged periods of time in an acceptable modality for application to the orbital region.

As far as drugs are concerned, astringent collyria have een used for several hundreds of years for the relief of xternal ocular inflammation. Ellis cites several formulas or such collyria:

4. *Dry Collyrium of Sugar*

Rx

Sacchari albi,
Oxidi Zinci, aa. partes equales.

Tere in pulverem. (Attributed to M. Recamier)

5. *Alum Curd*

Rx

Pulveris Aluminis, ʒ ss.
Albuminem Ovi, j

Agitate them well until a coagulum be formed. — To be applied on a linen rag to inflamed eyes. It should be removed in three or four hours.

6. *Alum Collyrium*

Rx

Pulveris Aluminis, gr. xij
Aquae rosarum, ℥ iv.

Fiat solutio. — To be applied to the eye in chronic inflammation.

7. *Collyrium of Acetate of Zinc*

Rx

Sulphatis Zinci,
Super-acetatis plumbi, aa. gr. vj
Aquae rosarum, ℥ iv

Fiat solutio. — To be applied to the eye.
Ellis's comment: "In this preparation a double decomposition takes place. Acetate of zinc is held in solution, while sulphate of lead falls to the bottom. It should be filtered or used without shaking."

And for soothing eye drops, try this one sometime:

8. *Emollient Collyrium*

Rx

Radicis Althaeae officinalis, ʒ ij
Aquae distillatae, lb. j

Infuse for three hours near the fire, and strain.
Ellis's comment: "Employed in inflammation of the conjunctiva accompanied with violent irritation."

The use of vegetable oils as an emollient protective coating for the eye was recommended in the 18th century. Early in the 20th century the local use of castor oil was introduced by the anesthetists to protect the cornea and conjunctiva from injury by the volatile ethyl ether which was commonly administered through a cloth-covered mask. This practice is still in vogue in some hospitals in spite of the fact that castor oil can be irritating if old and rancid. In modern ophthalmologic practice methyl cellulose solutions have almost completely replaced such vegetable oils, and these are offered in several different concentrations for specific purposes. Methylcellulose is a methyl ether of cellulose which swells when placed in water to produce a clear, opalescent, viscous colloidal suspension. Methylcellulose, 0.5%, in 0.9% sodium chloride solution is an excellent artificial tear and is very useful in the "dry eyes" of older patients and wherever a protective coating for the cornea is desired. More viscous (1%) solutions are used commonly as the contactant for the application of the gonioprism to the cornea.

True anti-inflammatory agents did not make their appearance on the therapeutic scene until the introduction of the anti-histaminics in the 1940's. There are many legend compounds on the market containing anti-histaminics for local application to the eye for the purpose of relieving inflammation, especially that due to allergies. The local use of anti-histaminics is of no proven value in such conditions of the eye, and may cause alteration of the presenting signs so as to mask more serious pathology later. There is no place in rational therapeutics for the use of locally applied anti-histaminics to the eye.

Mild vasoconstrictor solutions enjoy considerable popularity at the present time for relieving irritation of the eyes due to superficial vascular injection of the conjunctiva. This condition is frequently associated with allergic states, with exposure to environmental irritants, and with eyestrain. One of the most popular and effective preparations is the over-the-counter product marketed under the tradename, Visine^R. It contains 0.05% tetrahydrozoline as the vasoconstrictor agent. A popular legend drug with ophthalmologists is Vasocon^R, which contains 0.1% naphazoline as the sympathomimetic agent. Occasionally patients will exhibit adverse reactions to these preparations in the form of more severe congestion as the drug wears off, and rarely by dilatation of the pupils which lasts for several days and is quite annoying. These side effects clear promptly upon discontinuance of the drugs. The milder ZincFrin^R contains 0.25% zinc sulfate and 0.12% phenylephrine and rarely causes side effects.

The introduction of steroids in 1946 (ACTH) opened wide new vistas for therapy of both superficial and intraocular inflammations. The use of such preparations, systemically and especially locally, is widespread in ophthalmology and has restored many eyes to useful vision which would have been lost otherwise, However, the use of these compounds in the eye is not without some danger, so that no steroid medication should be prescribed except after careful and accurate diagnosis. Patients placed on such therapy require close and frequent observation by an ophthalmologist. What are some of the hazards? Well, in the first place, what may appear to be a trivial abrasion of the cornea may, in truth, be an early lesion of herpes simplex, the virus disease which is usually associated with fever blisters and canker sores of the mouth and lips. The use of steroids in such superficial herpetic keratitic infections may be disastrous and cause the patient to suffer serious loss of vision.

Another hazard: The continued use of steroid drops in the eye renders the eye susceptible to invasion by bacteria and fungi. The natural resistance of the eye is obtunded by the steroid in the collyrium. Many steroid eye drops are compounded to contain anti-infective agents for this reason. However, the use of antibiotic and sulfonamide drugs over long periods of time is hazardous in itself and should be discouraged.

And another hazard: It has been shown quite conclusively that the continued use of steroid preparations in the eye may cause an elevation of the intra-ocular tension and predispose the eye to glaucoma. Whenever the pathologic condition of the eye requires long-continued use of steroids locally, it is imperative that intra-ocular tension determinations be made with regularity by the ophthalmologist. Unfortunately, surveys have shown that most steroid eye preparations are prescribed by physicians other than ophthalmologists and usually for relatively trivial eye conditions for which the ophthalmologist would not deem steroids necessary or appropriate. I refer specifically to the indiscriminate prescribing of steroid eye drops in allergic patients, often to be used on a year 'round basis. Admittedly the use of a mild steroid eye drop toward the end of a severe hay fever season may bring the condition to a prompt and happy conclusion, and this is good ocular therapeutics. What we are condemning is the indiscriminate prescribing of potent steroid eye drops and ointments in patients with trivial trauma, undiagnosed mild inflammatio or low-grade chronic allergies affecting the eyes, not infrequently with the result that the patient develops a sequel to therapy which is more serious than the original conditio I would urge each of you to discipline yourselves not t refill steroid eye preparations for more than a time or tw without renewed orders by the prescribing physician. I cases of chronic or subacute inflammation of the uvea tract (iris, ciliary body and choroid) the continued nee for local and systemic steroid therapy may be genuine an the need may extend over a period of many months. T deny such a patient a single refill may cause an immediat relapse in the disease and lead to serious blindness. Th pharmacist and the physician should have a clear unde standing in each individual patient about refills on a steroid preparations. The burden of responsibility shoul be placed squarely where it belongs: on the shoulders the prescribing physician. The pharmacist should not allo himself to become the scapegoat in such cases.

Part II will be published in the July 1969 issue of *The Maryland Pharmacist.*

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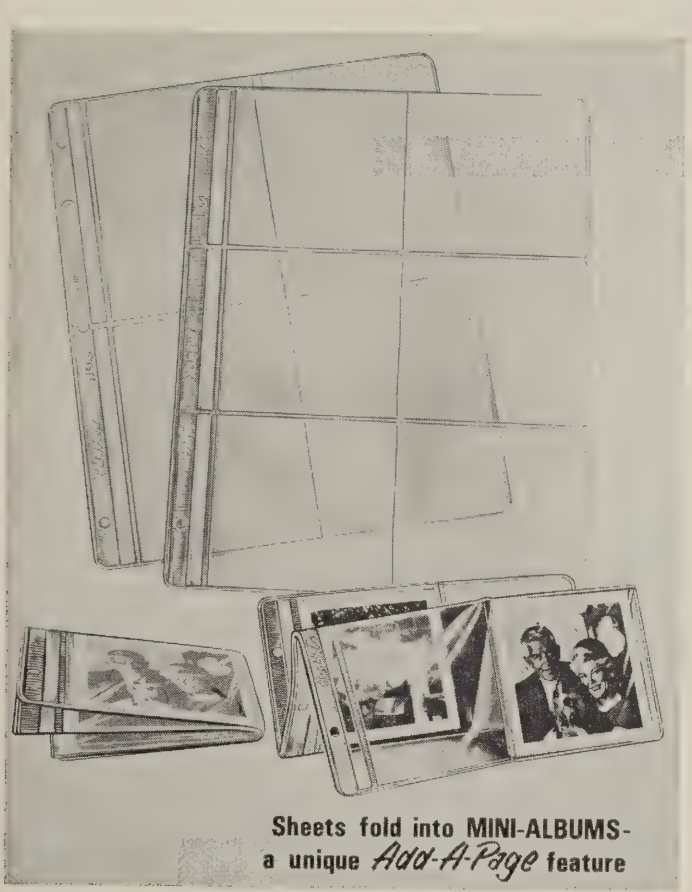

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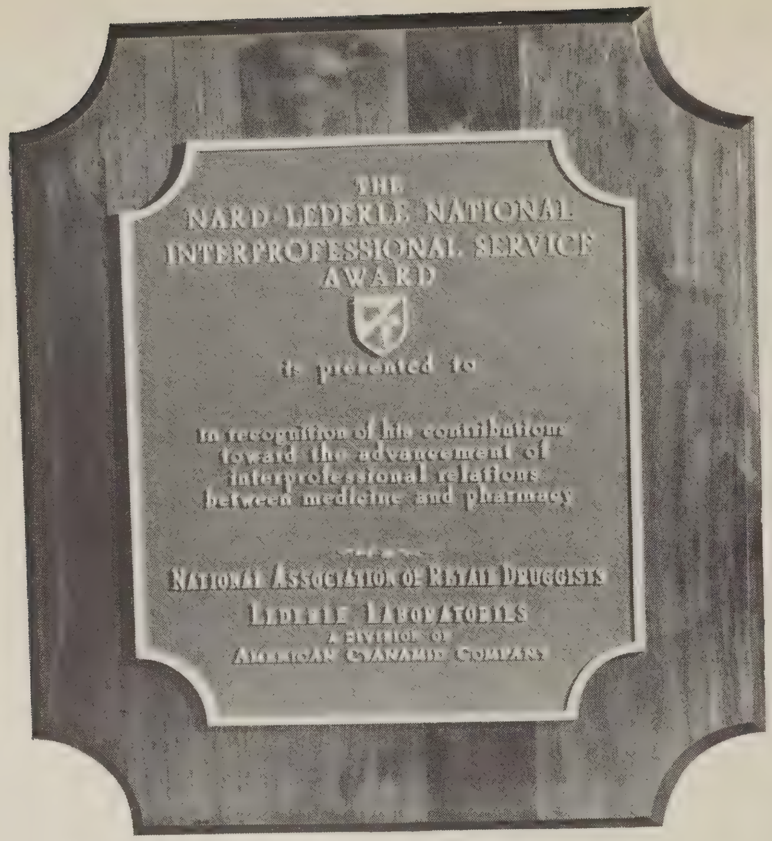
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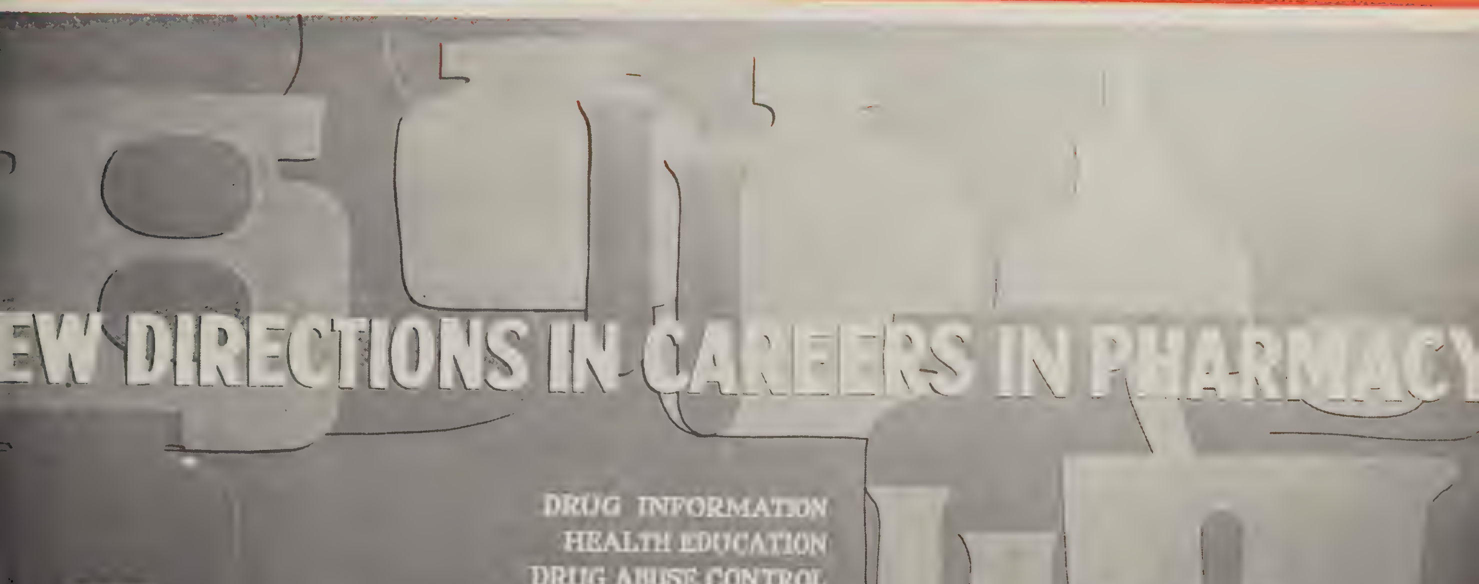
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(SEE PAGE 6)

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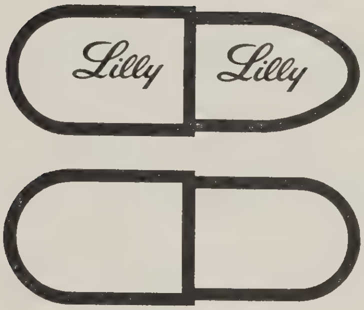

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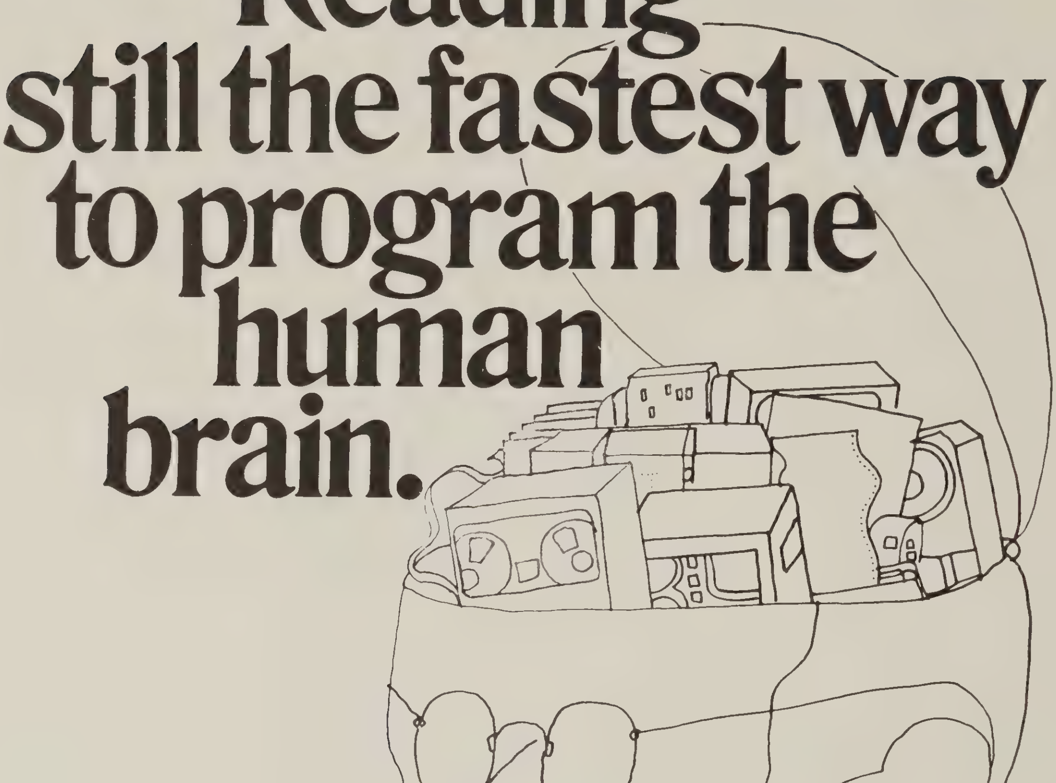

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Editorial . . .

Salaried Pharmacists — It's *Your* Profession Too!

In contrast to just a few years ago, *the majority of pharmacists are now salaried, staff or employee pharmacists.* That is why organized pharmacy, which has been slow in recognizing the importance of the salaried pharmacist in both the professional and economic aspects of pharmacy, must vigorously address itself to this fact of life.

The Maryland Pharmaceutical Association has long been open to full active voting membership for *all* pharmacists. Until this year progress has been slow in convincing salaried pharmacists of the desirability, in fact, of the necessity—in their own best self-interest—of joining their state professional society.

Programs to help meet the legitimate professional and economic aspirations of salaried pharmacists must be a high priority of the MPhA agenda. To this end we have to contribute to the development of meaningful guidelines for employer-employee relations. We hope that statesmanlike representatives of all facets of pharmacy will participate in this task so urgently required and important to the future of pharmacy as an independent profession free from domination by business, big government or big labor.

The Maryland Pharmaceutical Association has been stressing the concept of single unified profession of pharmacy made up of all pharmacists—whether community, hospital, proprietor, chain, government, educator, manufacturing drug sales or other—all supporting and participating in their state professional association.

Certainly it is time for the majority to step forward and forge the strong organized structure that can result from the recognition of this need and the committment to be a part of this effort. Criticism from outside the organization is not a constructive contribution to progress in meeting this critical issue.

In the meantime, we are gratified at the hightened interest on the part of salaried pharmacists in community practice (independent and chain) as well as those in institutional, faculty and administrative specialties. There is an increased awareness that all have a stake in pharmacy's future—that what affects one aspect of our profession results in a fallout that can radically alter other areas.

The concern of the younger pharmacists in our ranks is a healthy sign. They seek change and assert they are anxious to work within the MPhA to improve it so that there will be maximum responsiveness to current needs.

All of us—"establishment" and challengers—must work to develop the most effective organization to meet the challenges and opportunities facing pharmacy.

COVER STORY

"New Directions in Careers in Pharmacy" was the theme of the window display at the main building of the Enoch Pratt Free Library in Baltimore. The display was arranged on behalf of the Alumni Association of the University of Maryland.

President's Message . . .

It is with a great deal of pride and pleasure that I assume the post to which you have elected me.

I am not unmindful of the problems that have to be resolved and if I succeed at all it will be due to the assistance and cooperation of the officers, Executive Committee and active membership.

An organization is only as good and as strong as its membership and its muscle is directly dependent upon and proportionately as great as the number of members who belong.

The MPhA is an association for pharmacists, run by pharmacists. How far we can get in pharmacy is up to you. The more pharmacists we represent the more we will be heeded.

You owe it to yourself and your profession to back up your association with your money and yourself.

To accomplish our goals, we need you. To gain your ends, you need the Association. Send in your membership application right now. Let's start the engine rolling. We've been the donkey's tail for too long. Let's get together and move up front.

"JOIN YOUR ASSOCIATION—IT'S GOOD FOR YOU"
"TOGETHER WE CAN HELP PHARMACY AND OURSELVES"

I. Earl Kerpelman

Maryland Board of Pharmacy News . . .

Pharmacy Changes . . .

The following are the pharmacy changes for the mont of July:

New Pharmacies

Dart Drug Corp., Hilltop, Herbert H. Haft, President, 682 Race Track Road, Bowie, Maryland 20715.

Drug Fair No. 131, Milton L. Elsberg, President, 1050 In dustrial Boulevard, Cumberland, Maryland 21502.

Greenbelt Professional Pharmacy, Murry Gellman, Pres dent, 6201 Greenbelt Road—M-9, College Park, Mar land 20740.

White Cross, D. M. Robinson, President, 913 Taylor Av ue, Loch Raven Plaza, Towson, Maryland 21204.

Change of Ownership, Address Etc.

Churchville Pharmacy, Willis J. Williams (Change fro partnership to individual ownership), Rt. 22, Churc ville, Maryland 21028.

Cloverly Drugs, Joel Swartz—J. G. Carney (Former owned by N. Miller and I. Rubin), 712 Cloverly Stre Silver Spring, Maryland.

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**President Maryland Pharmaceutical Association
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I. Earl Kerpelman, Salisbury pharmacist, was elected President of the Maryland Pharmaceutical Association for 1969-70. He was raised in Baltimore and graduated from the Baltimore Polytechnic Institute and the University of Maryland School of Pharmacy, receiving his Ph.G. in 1929. He subsequently received an LL.B. from Blackstone School of Law in Chicago.

Long active in pharmaceutical association affairs, Earl Kerpelman was a leader in reactivating the Eastern Shore Pharmaceutical Society. He was greatly instrumental in drafting its By-Laws and served as its second President. The Society specifies membership in the MPhA as a prerequisite for membership in the area group.

In the MPhA, Mr. Kerpelman served as Chairman of the Simon Solomon Pharmacy Economics Seminar Committee and Chairman of the Social Committee and the 1969 Convention. He has served on the Executive Committee since 1963, representing District I (Eastern Shore.) He was elected a Vice President in 1966 and 1967 and elevated to President-elect in 1968.

Mr. Kerpelman's dedication to public and community service is indicated by the following record: Member, City of Salisbury Zoning Board of Appeals; Member, City of Salisbury City Manager Study Commission; Permanent Chairman, Exchange Club Medic-Alert Committee; Past President, Salisbury Exchange Club; Past Secretary, Maryland-District of Columbia Exchange Clubs; Past President, B'Nai Brith, Delmarva Lodge; Charter Member, Kena Shrine Temple, Alexandria, Va.; Jaycees Boss of the Year, 1962.

Mr. Kerpelman is a member of the Board of Governors, Beth Israel Congregation.

Mr. and Mrs. Kerpelman have two children: a daughter, who is a graduate of Penn State and is an art teacher in Baltimore and a son, who is a graduate of Princeton and holds a graduate fellowship for a Ph.D. degree at Yale in the History of the Theatre.

Mrs. Kerpelman (Frances) is a teacher of a special class of mentally retarded children.

LAMPA *News*

The Ladies Auxiliary of the
Maryland Pharmaceutical Association

The 16th Annual Convention Meeting and luncheon wa
held by LAMPA at Tamiment-in-the-Poconos, Pennsylvani
on Wednesday, July 16, 1969. Mrs. Harry L. Schrade
President, called the business meeting to order and intr
duced the incumbent officers and all past presidents wh
were in attendance.

The various annual reports reflected a busy and interes
ing year, with the balance in the treasury on the up-swin
Eight new members were welcomed during the conventio
Mrs. Anthony Padussis, Past-President, delivered the ke
note address, stressing the need for participation in pha
macy activities.

The entertainment programs were varied and imagin
tive, particularly Gilberto, the resident hair stylist at Tam
ment, who gave an informative wig show, with live model
some from the audience.

Mrs. Manuel Wagner delivered the invocation at t
luncheon which honored Mrs. Richard B. Crane, Co
responding Secretary, who was presented with a large silv
tray in recognition of her dedicated service to LAMP
Anne Crane has been greatly responsible for planning a
executing LAMPA projects for many years and has serv
in her present position for almost ten years.

Other LAMPA highlights included the Ladies Golf P
ting Tournament in which Mrs. Morton Lapides took t
honors, and Mrs. Louis Rockman, Vice-President, to
honors—at the other end. Most enjoyable and greatly a
preciated was a bus trip sponsored by Volos, Ltd., to W
ckoff's in Stroudsburg, where a Fall Fashions was p
sented.

Thanks were extended to Mrs. Charles Spigelmire, P
gram Chairman, for her efforts in making the conventi
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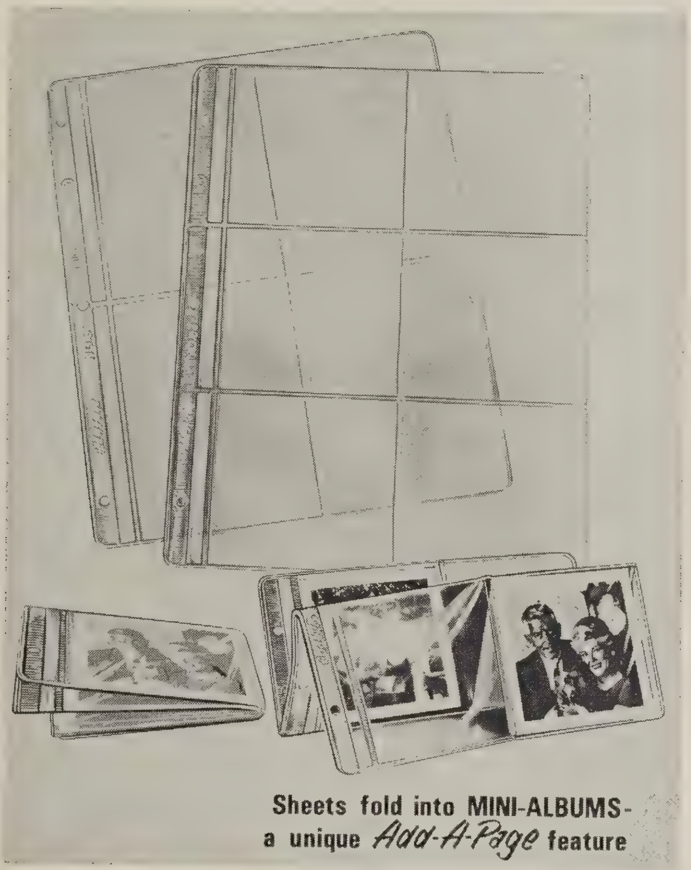
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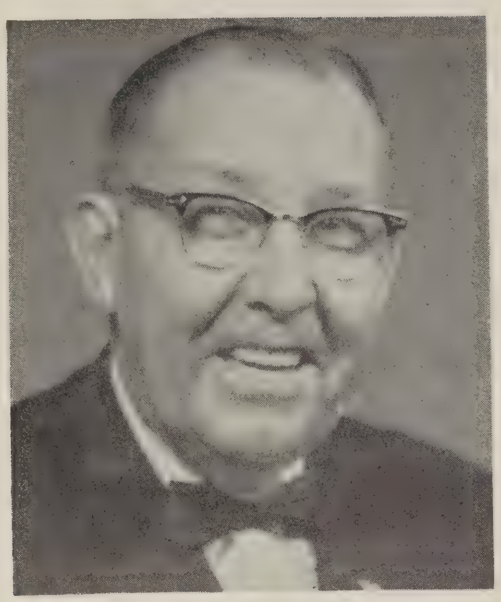
Obituaries . . .



WILMER A. F. PARKER

Wilmer Arthur Franklin ("Happy") Parker, 64, of Salisbury, an Associate Member of the Maryland Pharmaceutical Association and TAMPA died July 31. He was a member and chaplain of the Eastern Shore Pharmaceutical Society and a salesman for Loewy Drug Company.

"Happy" Parker, as he was universally known, regularly attended the regional meetings of MPhA. He was active on the Membership Committee, encouraging membership among Eastern Shore pharmacists. He served as a Deputy Sheriff of Wicomico County and was the first probation officer of the former Wicomico County Teen Age Traffic Court.

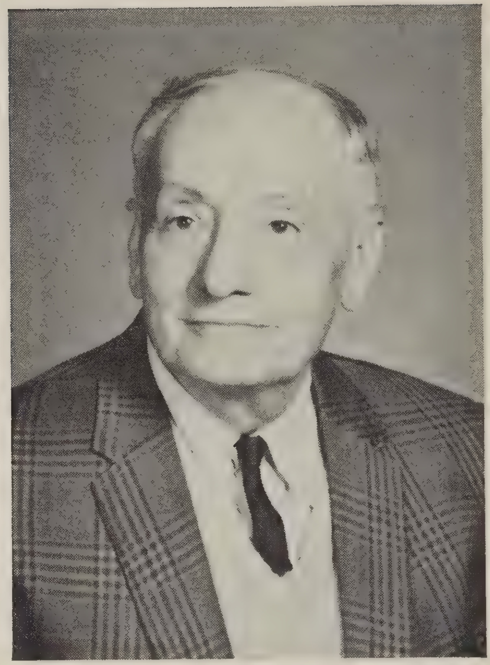
Mr. Parker was a member and chaplain of the Salisbury Exchange Club and in 1963 received the club's first plaque awarded for "outstanding service to youth." He was also an honorary life member of the National Exchange Club.

Active in the Masons, Mr. Parker was a member or chaplain of a number of lodges. He was a member of St. Peter's Episcopal Church.

Surviving are his wife, Mrs. Blanche Louise Wilson Parker; a brother Chester Lloyd Parker, Salisbury; three sisters, Mrs. Gladys Parker Parsons and Miss Margaret C. Parker, both of Salisbury, and Mrs. Louise Parker Flynn, Washington, D.C., and several nieces and nephews.

L. A. DEMELY, SR.

Louis A. Demely, Sr., 74, a pharmacy owner in Westport for more than 30 years, died June 4.



HERMAN M. KLING

Herman M. Kling, 64, a pharmacist in Baltimore fo more than 40 years, died June 23 at Greater Baltimor Medical Center after a long illness.

Mr. Kling was the owner of Flom's Drug Store on Eas Fayette Street, for the past 10 years. He had previousl owned Kling's Drug Store on Park Heights Avenue fo 25 years.

Born in New York, he was brought to Baltimore as youth and graduated from Baltimore City College, an from the University of Maryland School of Pharmacy i 1925.

He was editor of the yearbook at the School of Pharmac and later became first vice president of the school's alumn association.

Mr. Kling also edited the Baltimore Metropolitan Pha maceutical Association News Letter.

He was a member of St. John's Lodge, A.F. & A.M.

He is survived by his wife, the former Ada Snyder; tw daughters, Mrs. Barbara Cohen and Mrs. Suzanne Schwartz a sister, Mrs. Betty Taub, and a brother, Samuel Kling, a of Baltimore, and four grandchildren.

DUDLEY A. BURROWS

Dudley A. Burrows, 70, retired pharmacist and U. Internal Revenue employee, died on July 21, 1969. A gra uate of the University of Maryland School of Pharmacy 1922, Mr. Burrows was associated for seven years as own and manager of L. F. Franz and Company, North Aven and Aisquith Street. He was employed for a number years as a storekeeper with the Department of Internal Re enue, from which he retired about nine years ago. Aft his retirement from government service, he served as reli pharmacist at the former Cooper's Pharmacy and Pertno Pharmacy.

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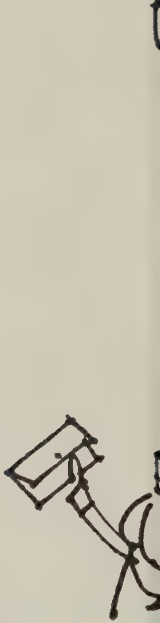

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Ophthalmic Therapy — Then and Now

Samuel L. Fox, M.D.*

Presented at the Ninth Annual Robert L. Swain Pharmacy Seminar on March 20, 1969, Holiday Inn-Downtown, Baltimore by the Maryland Pharmaceutical Association in conjunction with the University of Maryland School of Pharmacy.

Part II

(*Continued from June Issue*)

3. Anti-Infective Agents

Man has sought to conquer infection since the beginning of time. In the Old Testament the Book of Proverbs refers to the use of vinegar upon wounds (25:20). In the New Testament, Luke describes how wounds were treated in the manner of the Good Samaritan, who "bound up his wounds, pouring in oil and wine." (10:34). Chemicals such as copper sulphate and silver nitrate were described as being cauterizing agents for wounds in the early medical writings of the Romans and Greeks. In 1838, Ellis reported the following collyria "to be applied to weak eyes, and useful in ophthalmia after depletion."

9. *Collyrium of Vinegar*
   Rx
   Aceti distillati, ℥ j
   Spiritus Vini Diluti, ℥ ss.
   Aquae rosarum, ℥ viij
   Fiat mistura

10. *Collyrium of Sulphate of Copper*
    Rx
    Sulphatis Cupri, gr. vj
    Camphorae, ʒ j
    Aquae ferventis, ℥ viij
    Rub the camphor with the water—then strain, and add the sulphate of copper.
    Ellis's comment: "Recommended by Ware in the treatment of purulent ophthalmia"

11. *Collyrium of corrosive sublimate*
    Rx
    Hydrargyri Muriatis, gr. ij
    Aquae distillatae, ℥ viij
    Fiat solutio.
    Ellis's comment: "The above may be advantageously used in gonorrheal ophthalmia, as well as that of a scrofulous character."

It was not until 1907, however, that the first specific drug was developed. Paul Ehrlich, working with the chemist Bertheim, developed arsphenamine (Salvarsan^{R} or 606) for the treatment of syphilis. Ehrlich thus became the Father of Chemotherapy. The challenge enunciated by Ehrlich for a "*Therapia Sterilizans Magna*" taunted chemists for 50 years in their quest for singularly non-toxic synthetic antibacterial chemicals. In this search for the ideal chemotherapeutic agent, pharmaceutic chemists and physicians tested one heavy metal after another. Ophthalmic therapeutists participated in this "antiseptic era," and textbooks published in the early part of the 20th century recommended irrigations and drops of bichloride of mercury (1-10,000), cyanide of mercury (1-2,000), 1% and 2% silver nitrate solutions, 1% alcohol solution, creolin 1%, hydrogen peroxide solution, and various mixtures of copper sulphate, alum, zinc sulphate, and other heavy metal salts. Somewhat later the development of silver protein solutions (Argyrol^{R}, Neosilvol^{R}, Protargol^{R}, etc.) led to their immediate adoption as valuable antiseptic agents for the eye. With World War I came the synthesis of many dyes, and several of these found therapeutic usefulness as antiseptics. Mercurochrome^{R}, Merthiolate^{R}, Metaphen^{R} and a number of others appeared quickly in succession under the registered trade-names of the larger pharmaceutical manufacturers. They were widely used in the eye and some are still employed in eye preparations as preservatives. All are irritating to the eye and harmful to the cornea. None are prescribed today as anti-bacterial agents for the eye.

Among the other by-products of World War I was the synthesis of paraamino-benzene-sulfonamide, or sulfanilamide, by Gelmo in 1906 while working in the Technische Hochschule of Vienna. Gelmo was interested in dye chemistry for the war machine which Germany was then building and he had no reason to investigate the anti-bacterial properties of his new compound. It was not until 1932 tha Domagk, reviewing the discarded compounds develope two decades earlier, developed an active compound pos sessing this same chemical structure as part of the molecul and which proved effective in protecting mice against septi cemia caused by hemolytic streptococci. This drug wa named *Prontosil*^{R} and was patented in 1935 and hailed wide ly as the first break-through in Paul Ehrlich's dream for "specific" synthetic antibacterial agent. Additional sulfona mide compounds followed in quick succession. Some hav withstood the test of time and are still prescribed; other have been discarded because of toxicity of one type o another.

The sulfonamides are useful in the eye as anti-infectiv agents provided there is no frank pus present. Para-amin benzoic acid (PABA) is a structural analog of sulfanil mide and is an essential metabolite for bacterial reprodu tion. The presence of PABA will inhibit the action of th sulfonamides. PABA is present in pus, and hence the pre ence of frank pus will render the sulfonamide ineffecti as an anti-bacterial agent. Sulfacetamide has proven to the best agent of this group of drugs for the eye. It usually prescribed in 10 - 15% aqueous solution contai ing 0.5% methyl cellulose. There is also marketed a 30 solution in water without methyl cellulose (Sulamyd which is caustic and designed only for use in severe indole ulcers of the cornea. This should never be substituted the milder and weaker solution containing methyl cellulo Ointments are also available containing variable perce ages of sulfacetamide.

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* Dr. Fox is a graduate of the School of Pharmacy, University of Maryland ('34). He holds the ranks of Associate Professor of Ophthalmology and Assistant Professor of Pharmacology in the School of Medicine, University of Maryland, and he is Director of the Department of Ophthalmology at the South Baltimore General Hospital.

In 1928 Alexander Fleming, at Mary's Hospital in London, observed a contamination of a culture of staphylococci by spores of a species of *Penicillium* mold. Such contamination is not uncommon. Fleming, however, noted that the bacterial colonies surrounding a large colony of the contaminating mold had become transparent and were undergoing lysis. He suspected that the mold elaborated a substance antagonistic to the growth and survival of staphylococci. Subsequent experiments proved this observation to be correct. The elaborated substance was found to be effective against a variety of gram-positive organisms and to be non-toxic to animals. Fleming named this antibiotic substance *penicillin.*

Microbiologists had long recognized that a growing culture of one microorganism may be inhibitory to the growth of another micro-organism. Pasteur and Joubert, as early as 1877, observed that certain air-borne bacteria were capable of inhibiting the growth of anthrax bacilli. With Fleming's discovery of penicillin this aspect of microbiology took on great importance and a whole new field of research was developed in the search for more and better antibiotic substances. In 1944 *streptomycin* was isolated from Streptomyces griseus and in 1947 *chloramphenicol* (Chloromycetin^{R}) was isolated from Streptomyces venezuelae. This was followed by the isolation of other antibiotics and soon thereafter by the synthesis of one after another of these antibiotic compounds. The list is not yet complete.

Antibiotics which find considerable local usage in the eye include gramicidin, neomycin, polymyxin B, chloramphenicol, tetracycline, oxytetracycline, penicillin and bacitracin. In most such eye preparations several of the antibiotics are to be found so as to broaden the spectrum of effectiveness. These antibiotic ophthalmic preparations are usually packaged in sterile solution in small plastic drop-dispensing containers, to avoid the contamination which is almost inevitable with eye dropper containers. Some are also available as ophthalmic ointments.

Recently, gentamicin has been subjected to extensive clinical trial in a double-blind study by the author. It has been found to be the most effective antibiotic available for local use in the eye. Its spectrum is very broad, including gram-positive and gram-negative organisms, both cocci and rods. It is the most effective antibacterial agent yet tried against *Pseudomonas aeruginosa,* an organism dreaded by all ophthalmologists because of its destructive action on the cornea.** This antibiotic agent is already marketed as a dermatologic ointment and cream under the trade-name *Garamycin*^{R}, and will soon be available as an ophthalmic solution and ointment under the same trade-name.

Few antibiotics are effective in intra-ocular infections when administered systemically. Chloramphenicol (Chloromycetin^{R}) and erythromycin pass across the blood-aqueous barrier to provide therapeutic concentrations in the intraocular fluids of the eye. Penicillin, the tetracyclines and most other antibiotics do not provide effective intra-ocular evels and hence are no longer used for endophthalmic infections. Vancomycin penetrates the eye well but systemic usage must be carefully limited because of the ototoxicity of the drug.

Viral infections of the eye are not uncommon. Several known viruses attack the eye with regularity and may produce scarring and loss of vision. The common virus of herpes simplex has a marked predelection for the cornea. In recent years it was discovered that idoxuridine (IDU) is a specific drug against this virus. It appears that the virus requires the uptake of thymidin, an essential amino acid, as a metabolic precursor for reproduction. Idoxuridine (IDU) is closely related to thymidin structurally and effectively competes with this amino acid. This sharply reduces the reproductive capacity of the virus and ultimately causes its elimination from the tissues. Idoxuridine solutions are available under several trade-names (Stoxil^{R}, Herplex^{R}, and Dendrid^{R}) and at least one ointment preparation is on the market (Stoxil^{R}). These preparations have a short shelf-life and must be fresh to be effective. Since the solution must be instilled into the eye every hour around the clock, some prefer to use the ointment at nights especially. It is very important that the patient avoid the use of any topical steroid preparations during the attack of superficial keratitis produced by this virus, as the disease would then tend to invade the cornea and this would lead to more serious pathology and sequelae. It is also important that the patient be warned not to use boric acid solution, or eye preparations containing boric acid, along with the IDU preparations as boric acid renders the IDU extremely irritating to the eye.

Fungal infections of the eye may be primary, but usually are complications of long-standing usage of either anti-infective agents or steroid preparations or both. The suppression of the normal bacterial flora of the eye enables the fungi to invade the tissues. In such instances one must discontinue the use of all anti-infective agents and institute the local use of mild anti-fungal agents such as 2.5% sodium proprionate solution, or 0.1% solution of amphotericin B (Fungizone^{R}), or freshly made suspension of mycostatin (Nystatin^{R}) 100,000 units per cc. This latter preparation is unstable, but will retain about 90% of its effectiveness for 2 weeks if kept in the refrigerator. These preparations must be used every few hours for at least 5 days to avoid recurrences. Intra-ocular infestation with fungi or molds presents a greater challenge and offers less hope for a good result. The use of amphotericin B (Fungizone^{R}) intravenously in near-toxic doses has saved some eyes from total blindness.

Toxoplasmosis. With increasing regularity, opthalmologists are diagnosing a chorioretinal infection due to the Toxoplasma organism. This disease is a major cause of serious pathology of the retina, especially the macular area, and hence of blindness. The systemic use of a folic acid antagonist such as pyrimethamine (Daraprin^{R}) has proven helpful in many cases. However, use of the drug is fraught with many dangers and serious hematologic complications may occur. The drug is usually employed in conjunction with sulfadiazine, which exhibits a remarkable synergism with Daraprim^{R}.

4. Agents for Special Purposes

The eye represents a unique pharmacologic laboratory for the study of many special drugs. Its clear corneal window permits observation of the pupil and easy measurement of the accommodation in response to drugs which affect the autonomic nervous system. It is not surprising, therefore, that drug actions on the pupils were observed in ancient times. We shall review these special purpose drugs in several categories.

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*Very recently a vaccine has been developed against Pseudomonas, but it requires 3 or 4 days to become effective, and this is too long to be effective in eye infections.

a. Mydriatics and Cycloplegics

Belladonna has been known since ancient times. The name itself is a condensation of two words, *Bella Donna*, meaning "beautiful woman." The drug acquired this name owing to its use by the female to produce dilatation of the pupil for cosmetic purposes. Linnaeus recognized the poisonous nature of the plant and named it *Atropa*, after Atropos, the eldest of the three Fates—the one responsible for the cutting of the "thread of life." It was not until 1776, however, that the local action of the drug in the eye was rediscovered by a drug clerk, Daries, of Hamburg, who inadvertently rubbed some of the extract into his eye. He suffered a marked mydriasis and cycloplegia which persisted for many days. This led to further study of the drug. In 1881 atropine was isolated from belladonna and its chemical structure was identified. Soon thereafter all of the principal alkaloids of belladonna was isolated: atropine, hyoscyamine, and hyoscine (scopolamine).

In 1838 Ellis recorded the following usage for belladonna in the eye:

12. *Solution of Extract of Belladonna*

Rx

Extracti Belladonna, ℈ j
Aquae distillate, ℥ iij

Fiat solutio. Signa—To be applied to the eye in cases of cataract, for the purpose of dilating the pupil and exposing the lens.

Isaac Hays, in his 1847 revision of the classic textbook, "A Treatise on the Diseases of the Eye by W. Lawrence, F. R. S." states:

> "The influence of belladonna on the pupil had been observed long ago . . . but the attention of the profession was first expressly directed to the subject by Professor Himly, in some remarks on Paralysis of the Iris by the local application of Hyoscyamus, and the use of this remedy in the treatment of some diseases of the Eye," published in his "Ophthalmologische Beobachtungen," Bremen, 1801.

Dr. Hays adds, "The power in question resides in the atropa belladona (deadly night-shade), the hyoscyamus niger (henbane), the lauro cerasus (cherry laurel) and the datura stramonium (thorn apple). . . . The usual mode of proceeding is either to rub the moistened extract on the brow, or to drop a solution of it in distilled water into the eye: the last is the most efficacious."

With the isolation, and later the synthesis, of atropine, this alkaloid became the standard by which all other mydriatic-cycloplegics are compared. The action of atropine is slow in onset, often requiring instillation of the drug several times a day for several days to produce effective mydriasis and cycloplegia. Its action is similarly prolonged, lasting from 5 to 8 days as a rule. During this period of time the use of miotics has little or no effect in overcoming the effects of the atropine, and may precipitate a retinal detachment. The use of atropine in those over 40 years of age may occasionally precipitate an attack of closed angle glaucoma as a result of the intense and prolonged mydriasis.

The synthesis and introduction of homatropine into the armamentarium was hailed widely and proved a real boon as an aid for refraction and funduscopic examination of the eye. The drug acts in an hour or two after application to the eye (usually several applications are required at five minute intervals), and the effects last but 12 to 24 hours. In addition, the mydriasis can be overcome by the use of strong miotics, if necessary. The newer mydriatic-cycloplegic preparations, such as Mydriacy^R 1% and Cyclogyl^R 1% and 2%, have proven to be more useful than homatropine for refraction and have all but replaced it at the treatment table. Mydriasis and cycloplegia can be produced within 20 minutes with these newer preparations after one or two installations, and the effect is completely worn off within 4 to 6 hours. For treatment of intra-occular inflammation, or after surgery or trauma, the longer acting drugs such as atropine 1% solution or scopolamine 0.25% solution are to be preferred.

Whenever a parasympatholytic agent such as these is instilled into the eye, it is important to advise the patient (or the parent) to place digital pressure over the lacrimal duct for a few minutes to prevent the drug running into the nasopharynx and possibly being absorbed. It should be remembered that 0.2 ml. of 2% atropine sulfate solution or ointment contains 4 mgm. of atropine sulfate! This is a toxic dose if absorbed and can prove fatal in young children if repeated several times a day. The pharmacist can render a genuine professional service by reminding the patient (or parent) of this precaution.

There is widespread use of eye drops containing sympathomimetic amines for the temporary dilatation of the pupil in preparation for the examination of the intra-ocular structure with the ophthalmoscope (funduscopic examination). Such solutions include phenylephrine 10%, Mydriacyl^R 0.5%, Cyclomydril^R and Paredrine^R. Such preparations are generally instilled by the physician himself and are not useful for prescription use by the patient. They act quickly and the duration of action is quite short, usually less than an hour.

b. Miotics and Cyclotonics

Another large classification of drugs for special purposes in the eye are the miotics and cyclotonics. Perhaps the oldest known miotic is *eserine*, the active alkaloid obtained from the dried ripe seed of *Physostigma venenosum*, commonly called Calabar bean by native Africans. It is a powerful stimulant to the organs innervated by cholinergic fibers and causes contraction of skeletal muscle. This action is dependent upon its ability to inactivate cholinesterase, thus permitting uninterrupted action by acteylcholine. Because of its stimulation of the smooth muscle of the intestinal tract, peristalsis is initiated and evacuation is produced, so that it found wide usage in early times as a cathartic. It is still used occasionally for post-operative atony of the bowel, but the newer synthetic agent, Neostigmine^R is usually preferred by surgeons. Its action in the eye is that of a strong miotic and cyclotonic agent. Eserine salts are readily soluble in water, but such solutions are unstable and take on a pink coloration after a day or two. The solution is then less effective and irritating to the eye, and should be discarded. The drug is seldom used, therefore.

In 1876 Adolph Weber introduced the use of pilocarpin into ophthalmologic practice. He reported,

> "Inasmuch as I have for a while used an infusion o Jaborandi leaves with excellent success in my ophthalmological practice, the Merck Company sent me, fo experimental work, a preparation designated pilocarpin hydrochloride which is said to contain the alkaloid c Jaborandi. . . . The effect on the pupil is somewhat delayed but it lasts an average of 12 hours longer tha the other effects. When instilled into the eye itself, th average effect of 1 drop of a 2% solution is as follows

onset of constraction in 10 minutes; maximum contraction after 20-30 minutes; duration of maximum contraction: 3 hours; duration of some detectable narrowing: 24 hours."

Pilocarpine differs in its pharmacologic action from the other cholinergic agents by acting directly on the effector cells innervated by cholinergic nerves. Its action is not mediated through inactivation of cholinesterase and hence the drug retains its effectiveness when other similar drugs occasionally become ineffective after long usage. The effect in the eye from these drugs is not only one of miosis or contraction of the pupil, but also that of cyclotonia or increase in the power of accommodation. Several newer synthetic cholinergic agents have been introduced and at least one of these enjoys rather widespread usage at the present time: Phospholine Iodide^R solutions are marketed in varying concentrations. The cholinergic miotics have found increasing usage in the ever-increasing number of older patients with chronic open angle glaucoma. In addition, they are now prescribed in the medical management and treatment of accommodative strabismus, or cross-eyes, due to the presence of refractive errors and an abnormal accommodation-convergence ratio. It is important that the mother be warned to block off the lacrimal duct after application of these potent cholinergic drugs as serious toxic effects may result otherwise.

An unusual but effective therapeutic usage for the cholinergic agents is in the treatment of pediculosis of the eyelashes, and depends upon the toxic properties of the drugs. Occasionally patients are seen with blepharitis due to infestation of the lashes by pubic lice. The usual pesticides are difficult to apply in these areas without producing severe reactions in the eyes. The local use of eserine ointment, applied to the eyelashes several times a day for a day or two, will usually suffice to kill the Pediculus pubis and its nits. The ointment should be applied sparingly and carefully to avoid getting it in the eyes, but should this occur, only a temporary miosis will result.

c. *Anti-Glaucoma Drugs*

Glaucoma is the second most common cause of blindness in North America, being outranked only by cataracts. The disease appears to be on the increase as our population attains greater longevity, and it is now estimated that approximately 3% of the American population over the age of 45 are afflicted with open angle glaucoma.

We have already referred to the fact that cholinergic miotics are valuable drugs in the treatment of some forms of glaucoma. Indeed, they constitute the basis of our medical management of these cases. They act to increase aqueous outflow from the eye. In severe cases of the disease it is necessary to use additional drugs for control of the intraocular pressure, and in some instances surgery is required. Two types of drugs have proven to be valuable adjuncts in the treatment of glaucoma:

(1) Strong solutions of epinephrine salts applied locally to the eye

(2) The carbonic anhydrous inhibitors as oral tablets or by injection

These drugs exert their favorable influence by entirely different pharmacologic actions upon the eye.

The strong (1% or 2%) solutions of epinephrine salts act as powerful vasoconstrictors and their constrictive action on the blood vessels of the ciliary body adversely affects the production of aqueous humor. They may reduce the production rate by as much as 25% by the ischemia which they produce in the ciliary body. The carbonic anhydrous inhibitors, on the other hand, reduce aqueous production by interfering with the catalytic action of the carbonic anhydrous in the secretary cells of the ciliary body. This ultimately blocks the transfer of the sodium ion across the blood-aqueous barrier and may reduce aqueous production by as much as 30%. By reducing the volume of aqueous humor, the glaucomatous eye is better able to handle the elimination of aqueous from the eye and hence the intra-ocular tension falls.

Many patients require several or all of these measures for the medical management of their glaucoma. It is not unusual, therefore, to find a patient filling prescriptions for a miotic eye drop, an epinephrine preparation and a carbonic anhydrous inhibitor tablet such as Diamox^R. The pharmacist should be alert to notify the ophthalmologist if the patient is also taking any anti-cholinergic drugs, or a diuretic agent, or steroid preparations, as all of these will serve as effective blocks to successful treatment of the glaucoma. It should also be pointed out that patients who are on long-term therapy with carbonic anhydrous inhibitors may suffer potassium depletion and should take an adequate quantity of citrus fruit, bananas or other potassium-rich foods each day. The pharmacist should re-emphasize this need to the patient. It should be pointed out that many diuretics are also carbonic anhydrous inhibitors and the use of such diuretics along with similar anti-glaucoma agents may aggravate the potassium loss to a serious level. Whenever this situation is present, the physicians involved should be informed at once.

d. *Diagnostic Dyes*

The ophthalmologist employs several dye solutions to assist him in examining the tissues of the eye. Fluorescein sodium solutions 1% have long been used for staining corneal lesions. These solutions are extremely prone to contamination by *Pseudomonas aeruginosa,* and if infected solutions are applied to the injured cornea serious and permanent loss of vision may ensue. The use of this drug in multiple dose dropper bottles has been discarded by practically all ophthalmologists, therefore. The small sterile paper-impregnated strips (such as Fluor-I-Strip^R) and individual disposable containers of a single dose of sterile solution are much to be preferred, and are in general usage.

In the past several years fluorescein has been employed by intravenous injection to outline the circulation of the retina for study and photography in some cases of otherwise hidden retinal pathology. Of course, specially prepared solutions in sterile ampuls are required for these studies, which are always carried out in a hospital.

Another topical dye solution which is gaining in popularity is Rose Bengal 1% solution. This agent is especially helpful in studying the cornea of older patients. The solution is somewhat irritating to the eye and a drop of local anesthetic solution should be placed in the eye prior to the installation of the dye.

Modern Ophthalmic Therapy

Even from this cursory review of the therapy of the past, I believe you will agree that Oliver Wendell Holmes (1809-1894) was a physician of great wisdom when he concluded, in an address before the Boston Medical Society, with the words:

> "I firmly believe that if the whole of *materia medica* as now used, could be sunk to the bottom of the sea, it would be all the better for mankind and all the worse for the fishes."

Present-day concepts of modern ocular therapy differ greatly from the concepts in vogue even a decade ago. Whereas the topical route of administration remains the most popular one, drugs are now administered by a number of routes: topically, by subconjunctival injection, by retrobulbar injection, subcutaneously, and orally. Each route has its special indications and contraindications. It shall be our purpose this evening to discuss only the topical method of application of drugs to the eye, since this is the one with which you are most concerned.

Types of Topical Eye Preparations. The most common form in which drugs are applied to the eye is in solution. Solutions have several major advantages over other forms of medication: the contained active ingredients of a solution are always evenly distributed in the solvent: accurate dosage can be assured and controlled by proper design of the container; and such preparations are relatively easy to apply. On the other hand, solutions have the disadvantage of enjoying a relatively short contact with the eye. The solution quickly passes through the lacrimal duct and overflows onto the cheek by the tearing which follows its instillation into the eye. It has been shown that aqueous solutions remain in contact with the eye for a period of ½ to 1 minute only. The addition of methyl cellulose 0.5% or polyvinyl alcohol 1.4% increases the contact time to 5 to 7 minutes. Oily solutions and ointments also provide a contact time of 7 or 8 minutes, but have many disadvantages. It is necessary to use vegetable oils in most instances and these are subject to becoming rancid and irritating. Ointments cannot provide the controlled dosage of drops, nor assure as accurate distribution of the active ingredients, and frequently cause eczema of the face by prolonged contact with the skin. Some ointments cannot be rendered sterile. The "ideal preparation" is still the aqueous solution, therefore.

Criteria for Eye Solutions. For greatest effectiveness and maximum freedom from irritation, solutions of eye preparations should meet certain pharmaceutic and pharmacologic criteria:

(1) The preparation should have an aqueous base unless the peculiar nature of the active ingredients requires a different solvent.

(2) The solution should be isotonic with the tears of the eye. Although the eye tolerates well solutions of sodium chloride of 0.6% to 1.5% concentration, solutions should be prepared to have the isotonicity of 0.9% sodium chloride solution whenever possible.

(3) The solution should have a pH of approximately 7.3 as this is the normal pH of the tears. However, the eye tolerates well solutions with pH values of 6.6 to 9.0.

(4) It is preferable for the solution to contain buffer salts to assist in stabilizing the pH. This is not a critical requirement, however, as the tears are highly buffered.

(5) The solution should be sterile and self-sterilizing. Carefully selected preservatives may be necessary as additives to the solution.

(6) The solution should contain an additive such as methyl cellulose or polyvinyl alcohol to increase the contact time of the active ingredients with the ocular tissues.

(7) The solution should be dispensed in a container which provides some mechanism for delivering uniform and predictable dosage to the eye.

In conclusion, let me say that I have presented little that is new or original. My only claim to originality is in the format and manner of this presentation. I must confess with Goethe,

> "There would be little left of me if I were to discard what I owe to others."

But I do hope that the material presented to you this evening will be helpful to you in your work, and I thank you for the privilege of participating in this program.

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It is the common goal of government and industry to have drugs produced so that they uniformly meet all applicable standards. While we recognize that mistakes do occur, it is our joint responsibility to do everything possible to keep mistakes to a minimum.

When errors do occur, industry has the responsibility to take all action necessary to correct the situation. The Government has an obligation to check on industry and to see that the corrective actions taken are adequate to protect the consumer. Only with proper coordination and cooperation between industry and Government can the utmost protection be given at all times to users of drugs.

When a drug is found to be potentially, or definitely, hazardous to health, we believe it should be promptly recalled from the market. This procedure has been found to be the most expeditious and efficient mechanism by which stocks distributed over a large area, in possession of a number of consignees, can be quickly and efficiently removed from various channels of distribution or from the consumer's shelves.

Preventing Recalls

A review of the reasons for these recalls clearly shows that many could have been prevented by observing the principles of Good Manufacturing Practices. Let me pass on to you just two examples of recent costly recalls. Hindsight indicates they could have been avoided, if the major pharmaceutical manufacturers involved had strictly followed their own philosophy of proper controls at all stages of production.

Several drug manufacturers, who had gone to great lengths to set up proper finishing controls in their own plants, found it necessary to send the bulk product to outside firms for repackaging. However, they did not take the necessary precautions to see that the repackagers observed the necessary Good Manufacturing Practices in repackaging and labeling to prevent possible mixups. The result was labeling errors jeopardizing the health of users and thousands of dollars lost because of recall expenses in getting improperly labeled potent drugs off the market. Happily, we can report that the necessary corrective measures have been taken.

In another instance a large, responsible drug manufacturer was out of labels for two sizes of a particular product. To expedite matters, they ordered sticker labels from an outside printer without taking their normal precautions of using identity numbers on each label. The sticker labels, which were of similar color, design and composition were applied on the same production line on two lots of the same product, but each of a different potency, being run back to back. The foreman in charge of the relabeling ran out of sticker labels for one lot and ordered additional labels from the label room. There being no identity number assigned to the label, he referred to it by the product name. The label room issued sticker labels for the wrong size of the product, and the mistake was not detected. If the company had kept to its practice of using identity numbers on each piece of labeling this error would have been avoided.

Reasons for Recalls

A review of the records shows the following causes as the principal reasons for recalls during the past year: contamination with foreign material; significant deviation from required potency; revocation of antibiotic certificates; IND terminations; no NDA's; and withdrawals of NDA's; nonsterility; misbrandings, such as unwarranted claims for treatment of serious diseases, faulty disintegration and substandard qualities with regard to the monographs of official compendia, adulteration such as combination of mixed tablets in the same container, and label mixups.

A question has been raised as to how effective have manufacturers' recalls been. Frankly, we have not been happy with a number of these. For example, too often our effectiveness checks have shown unsatisfactory results, and the manufacturer has had to initiate a second recall effort. This has delayed getting the product off the market, to the detriment of the consumers. It is the manufacturer's responsibility to remove offending products promptly. He should also initiate his own effectiveness check promptly, and take necessary corrective action if the results aren't what they should have been. We feel that industry has had sufficient time to develop the necessary techniques and controls to remove from the market on the first go-around, any products which are dangerous or potentially dangerous to health.

FDA Action on Recalls

The Food and Drug Administration becomes aware o
recalls, or potential recalls, from factory inspections, sam
pling operations, professional or consumer complaints, in
jury reports from cooperating health officials or agencies
or information received directly from manufacturers, dis
tributors, or shippers. Whenever we learn that a product i
seriously misbranded or adulterated and has the potentia
of being dangerous, we immediately commit our resource
to developing necessary facts. This may include additiona
factory inspections, field investigations and laboratory ex
amination of samples. Having determined the basic fact
and that a problem exists, the next consideration is a scien
tific evaluation of the degree of danger involved. Ou
Bureau of Medicine and other Scientific Bureaus are r
sponsible for making this determination. It is a team oper
tion. Pharmacological and toxicological evaluations are co
sidered, and finally a medical evaluation is issued by th
Director of our Bureau of Medicine.

Having determined that there is a degree of dang
involved, the facts must be evaluated again to determi
the necessary depth of the recall and the means of co
munication to the consignees. In other words, should t
recall go to the wholesale, retail or to the consumer leve
Should the message go out by mass media, or by individu
messages, either telephone, telegram or first class mail?

Potential Product Dangers

The actual or potential danger to the individuals
ceiving the drug and the methods of distribution must
considered. Recall of a product distributed through who
sale, or branch warehouse, and then retail drug channels
the consumer is a different problem from that where
product is distributed directly to physicians and hospit
Other important considerations are whether or not reco
of distribution are such that individual units can be tra
directly to the ultimate recall level, or is it impossible
trace individual shipments, and therefore necessary to a

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*Adapted from a presentation at FDA Workshop for Dispensing Pharmacists jointly sponsored by Maryland Pharmaceutical Association, University of Maryland School of Pharmacy, Maryland Board of Pharmacy, and Baltimore District of the FDA.

every possible consignee, for example, all retail pharmacies in the country?

The Food and Drug Administration does not treat lightly the matter of requesting a recall. We recognize the burden a recall places on both industry and the Government, but the overriding factor must be the proper protection of the consumer. And the prime responsibility for getting the product off the market must be that of the manufacturers.

Authorization For Action

Recognizing that a recall is to be used only under the most serious situations, the Commissioner of Food and Drugs has ruled that only he or the Deputy Commissioner may authorize a recall requested by the Food and Drug Administration. Therefore, all the previously mentioned evaluations, considerations, and recommendations of FDA's staff are presented to the Commissioner for his final decision.

Once a decision has been made to request a recall it is generally presented to the manufacturer through the local Food and Drug District Office where the firm is located. You will find the district personnel fully cooperative in offering guidance, and in pointing out successful methods previously employed by others in similar situations.

It should be mentioned that there are many instances where firms have been too conservative in their initial recall effort or were not forthright in presenting the problem to consignees, and consequently the recall has been only partially successful. This results in additional time and expenses in finally getting the job done properly by a second, and more thorough recall attempt. Obviously much time and effort could have been saved by doing the job properly the first time. Our field offices can help you avoid this pitfall.

FDA Responsibilities

While a firm may voluntarily initiate a recall, we still have the responsibility to collect official samples, make proper examination, and to evaluate the depth and efficiency of the recall based upon our own medical and legal evaluation. At times it may be necessary for us to request a greater depth of action, or a more rapid, more effective course of action.

Our experience has shown that to be effective, the nitial recall notice must be forthright, brief, and to the point. It must demand the immediate attention of the con-ignees and impress them with the urgency of the matter. With the pressures of today's business, most wholesalers nd retailers are so preoccupied with daily problems that hey do not grasp the seriousness of recall situations unless he request is strongly worded and clearly brings forth the ense of urgency. It is far better in the long run to fully ccomplish an effective recall from the first communica-ions contract rather than having to repeat the initial efforts.

"Dear Pharmacist"

Listen to the following letter: "Dear Pharmacist: In eeping with our policy of providing you with only the ighest quality pharmaceuticals, we have made a recent nportant change in the formulation of our XYZ tablet. his has resulted in greater stability of the active ingredi-nts and reduced the hazard of the side effects. You will ecognize the new improved product by the change of design in the labels. All new improved XYZ tablets, whether 30's, 50's, or 100's, bear the new eye appealing blue and white quality seal in addition to the required labeling.

"Please return all old stocks of XYZ tablets for immediate credit or replacement."

As a pharmacist would you recognize this as a proper way to let you know that a product must be removed from the market because it has been rendered hazardous by cross contamination with penicillin? Of course, you wouldn't, and yet some firms will still try to hide the reason and need for recall behind varying degrees of sales promotion in their recall letter. We know from experience that such efforts will only fail.

"Important, Drug Recall"

A forthright recall letter should be sent first class mail and the envelope and letterhead are conspicuously marked (in red ink) *"IMPORTANT, DRUG RECALL,"* to prevent their being discarded as an advertisement. The letter includes a postage paid, self-addressed postcard which will be completed by the consignee to show amount on hand and its disposition. If no material is on hand, the consignee should so state and return the card promptly. If recall to the retail, hospital, or physician level is indicated, the manufacturer should see that the information gets down to the proper level.

The FDA field District in whose territory the manufacturer is located, is instructed to determine the areas of distribution and to advise other FDA Districts, in whose territory the product has been distributed, of pertinent details of the recall. Local and cooperating officials may also be notified of such details. If the offending product is exported, quite often it is necessary to bring the information to the attention of the foreign government through the State Department.

Monitoring Recalls

The field District also has a responsibility to monitor the firm's recall and to report to Washington headquarters regularly on the progress being made. It is also responsible for seeing that a recall does not lag because of indifference on the part of the manufacturer. We believe it is imperative that recalls proceed in a prompt fashion and that they be completed as soon as practical. Other FDA field Districts are requested to make spotchecks of designated consignees, after a reasonable period of time, to determine the completeness and effectiveness of the recall.

It is during these effectiveness checks that the pharmacists come into contact with the FDA inspector.

Our inspector will identify himself by showing his credentials and then ask for specific information. Did the consignee receive notification of the recall? If so, how and when? What instructions were received by the firm regarding disposition of the recalled material? How much material was on hand when the recall communication was received? Did the pharmacy follow the instructions of the recall? Then he will check the stock on hand to make sure none is left, and, finally, the inspector will inquire into any possible injuries or complaints associated with the use of the recalled product.

I would like to offer to you the full cooperation of the Food and Drug Administration, and its resources, for any recall problem you may experience.

It is my hope that through this brief discussion you will see the importance and impact of recalls from the manufacturer to the retail level.

Reunion—University of Maryland School of Pharmacy Class of 1939

FRONT ROW—LEFT TO RIGHT: Lawrence L. Lieberman, Nathan I. Gruz, Mario Sama, Harry L. Rochester, Angela Hackett Allen, Louis T. Sabatino, Albert Binstock, Eugene Jacobs, Daniel Baker.

CENTER ROW: Joseph U. Dorsch, Alvin Rosenthal, Irvin L. Kamanitz, Herbert D. Schneyer, Maurice Weiner, Alfred Alessi, Marion Shalowitz.

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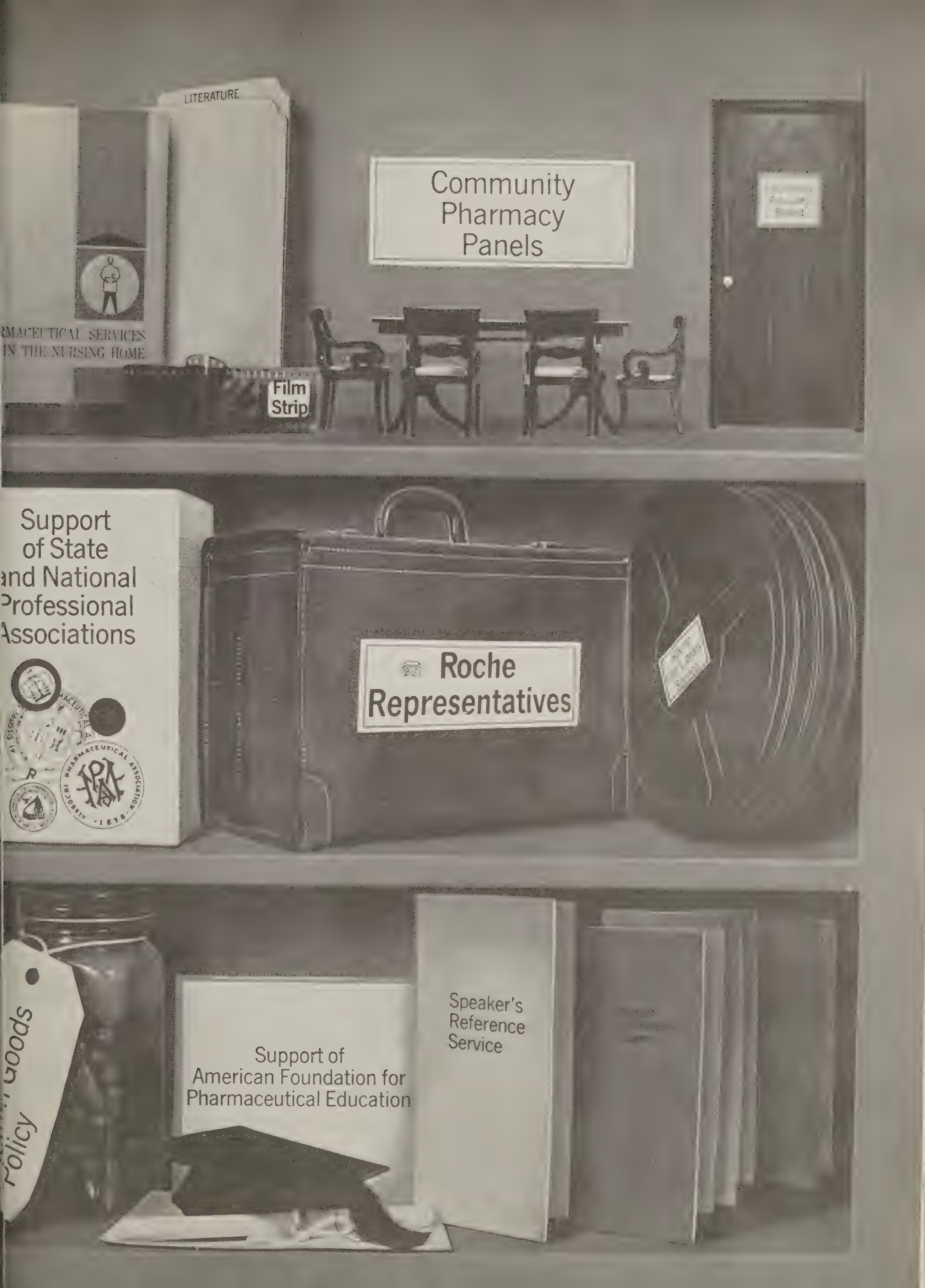
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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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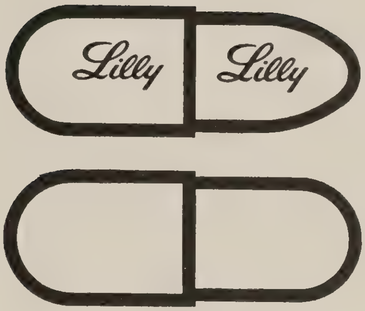

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Editorial . . .

Government And Third Parties In Pharmacy—The MPhA Role

By now, everyone, regardless of preference or philosophy, acknowledges that government not only is a weighty factor in all aspects of health care, but that governmental programs are growing rapidly. Government already is influencing strongly the kind of health delivery system that is emerging from what has been termed the "non-system." Existing governmental programs, new emerging programs, and those in the planning stage are designed to address the health delivery system to provide satisfactory medical care to all the entire population.

For pharmacy there are a number of developments that are shaping, where and how pharmacy is practiced.

Both individual citizens and organized groups of consumers are demanding access to quality health care at "reasonable costs." At the same time there are pressures on third party payment organizations to keep costs down. This applies to Medicaid, Blue Cross and union plans.

The Maryland Pharmaceutical Association during recent years has devoted more time to governmental activities and third party health plans than to any other programs.

We have presented the facts to justify reevaluation of administrative and reimbursement policies. By continuing frequent contacts we have seen results. Processing time for pharmacy services bills has been drastically reduced and payments are much more complete compared to just a few months ago.

Presentations made by Maryland Pharmaceutical Association representatives to the Governor, the Secretary of Health and his associates and the Budget Director have resulted in recognition that in order to obtain pharmacy services the pharmacist must be equitably reimbursed.

As a result of these MPhA efforts, the pharmacy service fee has been increased to $1.75 per eligible prescription, effective July 1, 1970 (fiscal 1971). This means an additional sum of about $550,000 to the pharmacists of Maryland, a sum that is urgently needed in order to realistically meet escalating expenses and galloping inflation.

The Maryland Pharmaceutical Association is now in the process of reviewing the Medicaid Program to determine how it can be improved. Analysis of current pharmaceutical economics is in progress, in order to document the gap between the projected and realistic compensation to pharmacists, who work to provide complete professional pharmaceutical services to all their patrons.

Maryland Board of Pharmacy News . . .

Pharmacy Changes . . .

Pharmacy Changes for the month of January:

New Pharmacies

Giant Pharmacy No. 206, J. B. Danzansky, President, 15660 Annapolis Road, Bowie, Maryland 20715.

Drug Fair No. 133, Milton L. Elsberg, President, Route 197, Laurel-Bowie Road, Laurel, Maryland 20810.

Dart Drug Corporation, Adelphi, Herbert H. Haft, President, 2340 University Boulevard, East Adelphi, Maryland.

Garwyn Pharmacy, James M. Young, 2300 Garrison Boulevard, Baltimore, Maryland 21215.

Columbia Hospital and Clinics Foundation, Inc., R. M. Heyssel, President, Columbia, Maryland 21043.

Change of Ownership, Address, Etc.

Village Drugs, Inc.—Pine Grove, Robert E. Baxter, President, 399 Fort Smallwood Road, Pasadena, Maryland 21122 (Change from Corp. to Individual Ownership).

Bobs Village Drugs, Inc., Robert E. Baxter, President, 2932 Mountain Road, Pasadena, Maryland 21122 (Change from Corp. to Individual Ownership).

Pharmacy Changes for the Month of February:

New Pharmacies

Giant Pharmacy No. 207, J. B. Danzansky, 81 Forest Drive, Annapolis, Maryland 21401.

Madison Park Professional Pharmacy, Wesley N Shelton, President, North Avenue and Eutaw Street, Baltimore, Maryland 21201.

Prince George's General Hospital, Mrs. Gladys Spellman, Chairman, Cheverly, Maryland 20785.

Change of Ownership, Address, Etc.

None.

No Longer Operating as Pharmacies

Block's Pharmacy, Israel A. Levin, 4623 Reisterstow Road, Baltimore, Maryland 21215.

Hahn & Hahn Homeopathic Pharmacy, Albert G. Hahr Jr., 324 West Saratoga Street, Baltimore, Maryland 21201.

Robinson's Drug Store, Lester Robinson, 2139 Pennsy vania Avenue, Baltimore, Maryland 21217.

Rochester's Pharmacy, Harry L. Rochester, 521 Reisterstown Road, Baltimore, Maryland 21215.

Pharmacy Changes for the month of March:

New Pharmacies

Thrift Drug Company, Louis L. Avner, 2444 Churc ville Road, Campus Hills Shopping Center, Bel Air Mar land 21014.

Q. & B. Pharmacy, Ralph Quarles and Willard Bulge 2219 Pennsylvania Avenue, Baltimore, Maryland 21217.

Change of Ownership, Address, Etc.

State Pharmacy, Jerome Berger, President, 7900 H ford Road, Baltimore Maryland 21234.

Richman's Pharmacy, Inc., Mr. and Mrs. George Brandt, 1515 Bloomingdale Road, Baltimore, Maryland 21216.

Star O'Nevins Pharmacy, Matthew J. Nevins, Jr., 5814 Belair Road, Baltimore, Maryland 21206.

No Longer Operating as Pharmacies

White Cross, D. M. Robinson, President, 319 North Howard Street, Baltimore, Maryland 21201.

Chatkins North End Pharmacy, William C. Chatkin, President, 583 Northern Avenue, Hagerstown, Maryland.

Pharmacy Changes for the month of April:

New Pharmacies

Dart Drug Corporation, Hampton Mall, Herbert H. Haft, President, 9185 Central Avenue, Capital Heights, Maryland 20027.

No Longer Operating as Pharmacies

Muehlhause Pharmacy, M. Evans Hilliard, 4943 Belair Road, Baltimore, Maryland 21206.

Change of Ownership, Address, Etc.

None.

Pharmacy Changes for the month of May:

New Pharmacies

Levay Community Pharmacy, Frank F. Levay, President, 8228 Fort Smallwood Road, Baltimore, Maryland 21226.

Sentry Drug Center No. 02, Samuel C. Lang, President, 1818 Virginia Avenue, Old Orchard Shopping Center, Hagerstown, Maryland 21740.

No Longer Operating as Pharmacies

Rasinsky's Pharmacy, Milton Rasinsky, 30 West Main Street, Westminster, Maryland 21157.

Allen's Pharmacy, Anthony Allen, III, 1601 Edmondson Avenue, Baltimore, Maryland 21223.

Morgan and Millard, Inc., Charles J. Neun, President, 301 East Baltimore Street, Baltimore, Maryland 21202.

Change of Ownership, Address, Etc.

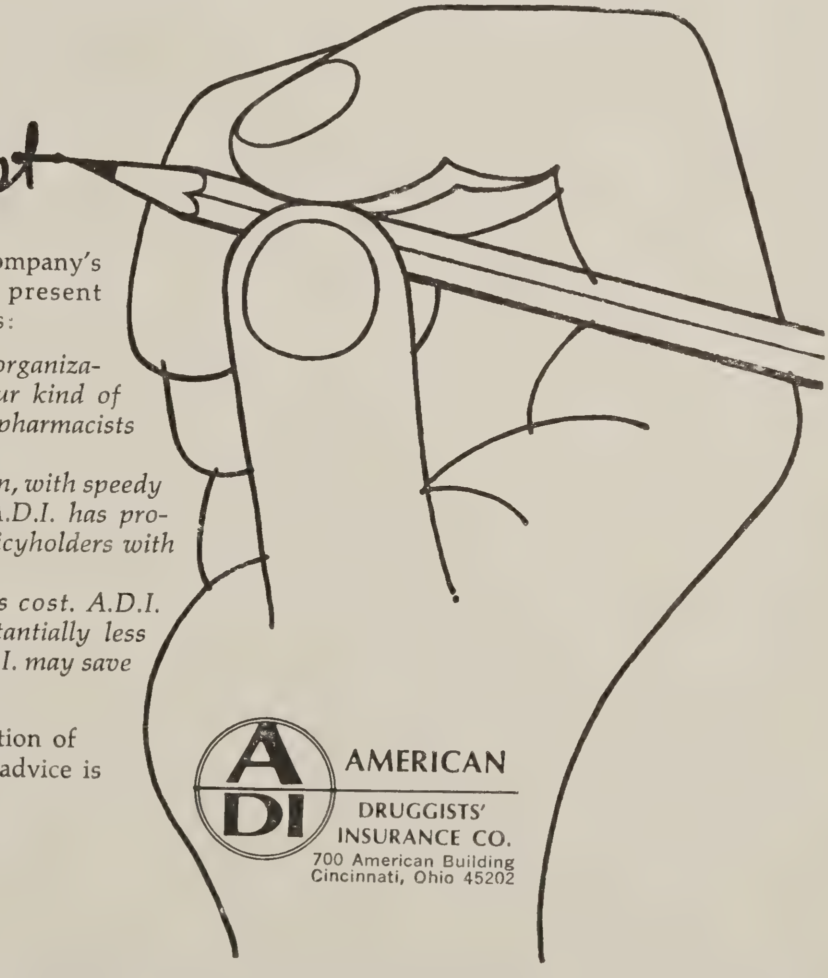
B. T. Smith Company, Inc., David Rombro, President, 1122 North Charles Street, Baltimore, Maryland 21201.

Hampstead Pharmacy, Inc., Walter H. Abel, 38 North Main Street, Hampstead, Maryland 21074.

OBITUARY

FRANK C. PICHA

Frank C. Picha, 67, member of the MPhA and BMPA, who retired in 1967 after 38 years service with Read Drug Stores, died June 26th. He was a 1928 graduate of the University of Maryland School of Pharmacy. He is survived by his widow, Marie, and a son and daughter.



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- *The third consideration, of course, is cost. A.D.I. provides insurance coverage for substantially less than the average premium. In fact, A.D.I. may save you up to 20% of your coverage costs.*

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Program 88th Annual Convention Maryland Pharmaceutical Association

in conjunction with
LAMPA and TAMPA
The Ladies and Travelers Auxiliaries
THE SHELBURNE HOTEL
Atlantic City, New Jersey
July 12-16, 1970

HIGHLIGHTS

SUNDAY, JULY 12

6:00 P.M. Opening Cocktail Party for all registrants
Dinner
9:00 P.M. Hospitality Room—Music
10:00 P.M. Art Auction—Fun and Bargains from the National Art Auction Gallery

MONDAY, JULY 13

10:00 A.M. FIRST BUSINESS SESSION
Convention Call to Order—President I. Earl Kerpelman
Invocation
Opening Remarks—President Kerpelman
Communications
Committee Reports
Treasurer's Report
Report of Board of Pharmacy
Report of School of Pharmacy
Announcements
Attendance Prizes
Adjournment
1:00 P.M. Poolside Picnic
Entertainment
9:00 P.M. Depart for Club Harlem
Lon Fontaine's Club Harlem Review of 1971, Starring Harold Dumont

TUESDAY, JULY 14,—SECOND SESSION

9:15 A.M. Call to Order—President Kerpelman
Early Bird Attendance Prize
Address of President Kerpelman
Report of Executive Secretary—Nathan I. Gruz
Prize Drawings
"National Health Insurance"—Dr. David M. French, Professor and Chairman, Department of Community Medicine, Boston University; Member of Committee of 100 for National Health Insurance
"The Pharmacist in Patient Care—A New Clinical Role"—Patrick H. Birmingham, Director of the Department of Pharmacy and Medical Supply and Murray P. Ginsberg, Staff Pharmacist, Good Samaritan Hospital, Baltimore
Announcements
Prize Drawings
1:00 P.M. Adjournment
Entertainment
10:00 A.M. LAMPA—Bus Trip to Renault Winery and Smithville Inn—Luncheon and Annual Meeting at Smithville Inn—Prizes and Gifts
9:00 P.M. TAMPA Night—An unusual Bingo Party with the ladies of LAMPA presenting a "between the acts" fashion show. Prizes galore. Fun for all.
10:00 P.M. Presidential Cocktail Party—Courtesy Young Drug Products

WEDNESDAY, JULY 15—THIRD SESSION

9:00 A.M. Registration Desk Opens
9:15 A.M. Call to Order—President Kerpelman
Early Bird Attendance Prize
Communications
Memorial Services
Report of Legal Counsel—Joseph S. Kaufman
"Toward Unity and Strength in Pharmacy—APhA and the State Associations" William R. Whitten, President American Pharmaceutical Association
Old Business
New Business—Resolutions
Report of Nominating Committee
Election of Officers and Members of the Executive Committee
Election of Nominees for the State Board of Pharmacy
Prize Drawings
1:00 P.M. Adjournment
2:00 P.M. TAMPA Annual Meeting
6:30 P.M. Cocktail Party—In Honor of MPhA Sustaining Members
7:30 P.M. Annual Banquet
Greetings from Governor Mandel
Installation of MPhA Officers
Presentation of TAMPA Officers
Installation of LAMPA Officers
Awards and Prizes Dancing

THURSDAY JULY 16—FOURTH SESSION

9:00 A.M. Registration Desk Opens
9:15 A.M. Call to Order—President Kerpelman
Early Bird Attendance Prize
"New Developments in Delivery of Healt Services"—Dr. Matthew Tayback, As sistant Secretary of Health and Menta Hygiene
Report on State Medicaid Program
"Pharmacy Laws and APhA Policies—Anti substitution and Other Issues"—Ca Roberts, Director of the Legal Divisio American Pharmaceutical Association
State Legislative Proposals for 197
Report on Third Party Programs
Prize Drawings
1:00 P.M. Adjournment

Reputation...
it often depends
on the company
you keep.
Butazolidin
phenylbutazone
100 m
Geigy
1000 tablets
Caution: Federal law prohibits dispensing without prescription
Average Dosage
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Zeitz's
227
Mr. J. Sh
as directed
Dr. H. Mu
PRESCRIPTION
Tofrānil®
Brand of
imipramine hydrochloride
Geigy
25 mg.
1000 tablets
Caution: Federal law prohibits dispensing without prescription
Dosage

Convention Speakers

DR. DAVID M. FRENCH

SUBJECT: "National Health Insurance"

Assuming and paying for quality health care for all, as we all know so well, is uppermost in the minds of both the public as well as health professionals. Prominent in attempting to meet this concern are proposals for some kind of "National Health Insurance." In order to bring about an intensive and extensive study of this issue by a representative cross section of leaders from every facet of American society, the late Walter Reuther initiated the "Committee of 100 for a National Health Insurance."

Dr. David M. French, Professor and Chairman, Department of Community Medicine, School of Medicine, Boston University since 1969 is a member of the "Committee of 100 for National Health Insurance."

Dr. French, a native of Toledo, Ohio, is a graduate of Western Reserve University in 1944. He served in the U.S. Army in 1944 and enrolled in the Howard University, College of Medicine, where he received his M.D. degree. After completing his residency in General Surgery he engaged in private practice until 1957.

Dr. French then joined the faculty of Howard University. He became Associate Professor of Surgery and was Coordinator (Associate Dean) for teaching services at the D. C. General Hospital. He served as a Fellow at Children's Memorial Hospital, Northwestern University, Chicago, and was in charge of the Howard University Pediatric Surgical Services from 1960-67.

Dr. French was a Fellow, Department of Medical Care and Hospitals at Johns Hopkins University, receiving a Master's degree in Public Health. He holds membership in many professional societies and was past national president of the Medical Committee for Human Rights. He is a Diplomate, American Board of Surgery, Fellow, American College of Surgeons and author of many articles and professional journals.

PATRICK H. BIRMINGHAM

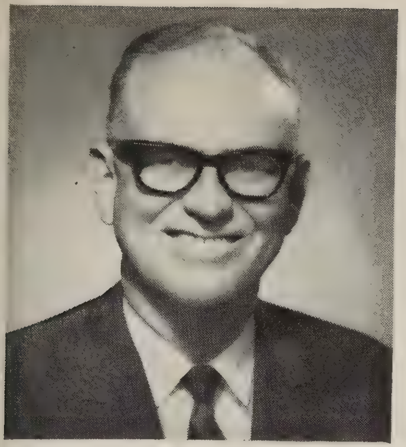
SUBJECT: "Pharmacist and Patient Care—
A New Clinical Role"

Is involvement with patient therapy a proper role fo pharmacists? A growing number of pharmacists, physicians, nurses and others are convinced that pharmacist must be involved in every aspect of drug therapy fron choice of medication to patient follow-up subsequent to administration. An on-going program of this nature is no in operation at the Good Samaritan Hospital in Baltimor

Patrick H. Birmingham, Director of the Departme of Pharmacy and Medical Supply at the Good Samarita Hospital has presented the program in effect at his instit tion before the Annual Clinical Meeting of the America Society of Hospital Pharmacists in December 1969, and th Annual Hospital Seminar of the Maryland Society of Ho pital Pharmacists in June of this year.

He is a native of Pittsburgh, Pennsylvania and a grad ate of Duquesne University in 1965, where he had he office as president of the Student Branch of the Americ Pharmaceutical Association. He is also a member of t American Society of Hospital Pharmacists and active in t Maryland Society of Hospital Pharmacists. He has work as an apprentice pharmacist in a community pharmacy a as an intern pharmacist at the Western Pennsylvania H pital in Pittsburgh. He served in the Department of Ph macy Services of the Johns Hopkins Hospital from July 1965 until June 1968, when he was appointed to his pres position.

Pat Birmingham is a pharmacist with great confide in the potentialities and capabilities of today's pharmac to serve as a full member of the health team along side physician and nurse. He is justifiably proud of the insti tion and the pharmacy service which he manages and more than eager to give you a grand tour which will well worth your while.



WILLIAM R. WHITTEN

SUBJECT: "Toward Unity and Strength in Pharmacy— APhA and the State Associations"

William R. Whitten, American Pharmaceutical Association President, is a practicing pharmacist in Fort Worth, Texas. He was installed in office on April 16, 1970 and will serve as President through the 118th Annual Meeting of the Association, which will be held in San Francisco, California from March 27-April 2.

President Whitten was born in Bogata, Texas on August 25, 1921. He attended the University of Texas College of Pharmacy and received his Bachelor of Science degree in 1947. He is President of Whitten Pharmacies, a firm of seven pharmacies. In 1965, he received the Longhorn Pharmaceutical Association Merit Award for advancing pharmaceutical education, and in 1966, he received the Texas Pharmaceutical Association's highest award when he was selected as Texas' "Pharmacist of the Year". In 1963, he was appointed to the Texas State Board of Pharmacy and served as Board President in 1967-68. He is a past member of the Advisory Council of the University of Texas Pharmaceutical Foundation and is an Honorary Member of Kappa Psi.

President Whitten joined APhA in 1947 and has served on several committees. He was Speaker of the APhA House of Delegates in 1966 and served on the APhA Board of Trustees from 1967-70. He was a regional director of the American College of Apothecaries from 1965 63.

DR. MATTHEW TAYBACK

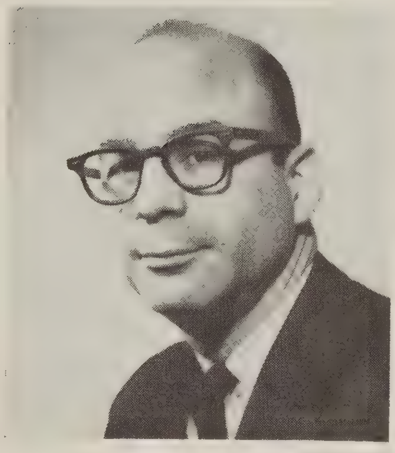
SUBJECT: "New Developments in Delivery of Health Services"

Dr. Matthew Tayback, the Assistant Secretary of Health nd Mental Hygiene for Scientific Affairs for the State f Maryland, is responsible for programs involving delivery f health services, including Medicaid.

Dr. Tayback was formerly Deputy Commissioner of Health for Baltimore City and Professor of Preventive Medicine at the University of Maryland School of Medicine. He is a lecturer at Johns Hopkins School of Hygiene and Public Health, and is a consultant to the Rockefeller Foundation, Ford Foundation, Children's Bureau, Edgewood Arsenal, Alliance for Progress and A.I.D.

He received his B.A. from Columbia, M.A. from Harvard and Doctor of Science degree from Johns Hopkins. He holds the rank of Lt. Col. in the U.S. Army Medical Service Corps Reserve (retired.)

Dr. Tayback has been concerned for many years with methods for improving the quantity and quality of health care in areas deficient in medical facilities and personnel.



CARL ROBERTS

SUBJECT: "Pharmacy Laws and APhA Policies— Antisubstitution and Other Issues"

Carl Roberts, the Director of the Legal Division of the American Pharmaceutical Association, is a native of Boston, Massachusetts and was raised in West Hartford, Connecticut.

He obtained a B.S. Degree from Syracuse University in 1953 as a Radio-Television Major. He received the J.D. Law Degree at the University of Michigan in 1960. He has been admitted to practice in the State of Connecticut and the District of Columbia. Mr. Roberts has had a wide range of legal experience, having served as a Government Attorney with the Federal Communications Commission and the Department of Health, Education and Welfare. He has also been engaged in private law practice in Washington, D.C.

Mr. Roberts is a member of: American Bar Association, Federal Bar Association, National Association of College and University Attorneys and the Federal Communications Bar Association.

Mr. Roberts is married and lives with his wife and three children in Rockville, Maryland.

Facts from a Pharmacist's Wife

Being a pharmacist's wife is taking your young children to the drugstore so that they will know which man is Daddy; listening proudly while they tell their playmates that Daddy makes medicines to help people. It is waiting in the drugstore while your husband fills a prescription telephoned in two minutes before closing time for a customer who "will be down in fifteen minutes" and comes in forty-five; later learning from a grateful parent that it was so kind of my husband to wait for him.

Being a pharmacist's wife is: Having acquaintances make snide remarks about money-grubbers who keep their drugstore open mornings, evenings and holidays; seeing them dash in on a Sunday for the refill prescription needed in an emergency or a prescription for the nausea which struck little Jimmy in Sunday School. It is having your husband know who is pregnant, who is having mental or marital difficulties and who has interesting ailments, and being the last to know because an ethical pharmacist keeps all such private communications to himself.

Being a pharmacist's wife is: Knowing that your husband listens patiently to little old ladies tell about their aches and pains; responds with sympathetic advice to young adolescents confused by the signs of maturity.

A pharmacist's wife knows: That pharmacy is an intangible, unpredictable profession which combines exact knowledge and skill with caring for and caring about people.

What is a pharmacist? A pharmacist is a person who practices a profession which takes five years of college—six years in some states—and a year of internship under the constant eye of a registered pharmacist, and the satisfactory completion of a three day examination given by the Board of Pharmacy. This examination consists of a display of practical information and skill needed in compounding prescriptions as well as a written test of general pharmaceutical knowledge. He is a person who must work closely with physicians. It is a pharmacist's obligation to back up the busy doctor with his knowledge of the amounts of certain drugs which are safe to ingest, his experience in chemical processes which supplies the physician with the right catalyst to make several diverse drugs into a healing medication, and his knowledge of the uses of the newest drugs on the market. The pharmacist's work is based on constant study. There are hundreds of drugs in the pharmaceutical formularies and new drugs are added every week.

The pharmacist must decode the prescription and fill it with the exact drug requested. A pharmacist must keep strict watch over the narcotics and drug abuse drugs entrusted to his care. He must notify the physican if he has reason to suspect that his patient is abusing rather than using wisely a prescription for narcotics or other drugs. A pharmacist is a one man welfare station who donates cash and prizes to civic and religious organizations, sells tickets—"No, he does not get a rake-off"—and lends his presence, on his few hours off, to meetings and other activities.

A pharmacist's wife knows that a pharmacist is a necessary adjunct to the physician, a student who must keep up with the new drugs and medicine, a confidante to young and old, a narcotics and drug abuse detective, a civic minded citizen, a professional whose ethical standards must be high—a public servant in the highest sense of the word.

—F.K.

L.A.M.P.A.—Be *Involved*—Ask Friends to Join You

Individual L. A. M. P. A. members are in the position to stimulate and clarify issues and help move the Association ahead. It is not enough for the state organization to make "appropriate statements" and to take "string positions". It is on the "commitment to action" of the individual member that the future of the Association and the profession as a whole depends.

Each of us is caught in the center of multitudenous change. We are bombarded by new demands on our time and talents, urged into actions for which we may not be prepared, confronted with increasingly difficult choices.

To be involved aims to inspire other less involved members to make the "commitment to action". Why do we spend so much time and effort learning to assist in problems and apparently ignore the fact that many problems can be prevented if every one took an interest and part.

To be involved has three major thrusts: (1) involve members into action. (2) involve prospective members in the action and activities of L. A. M. P. A. (3) Call public attention to L. A. M. P. A.'s contribution both in the profession and the community.

I suggest that we dedicate ourselves to effective action.

Let us all, individually and collectively, start now. *Let Be Involved.*

Mrs. Harry L. Schrader,
President L.A.M.P.A.

Narcotic and Controlled Drug Thefts, Must Be Reported

The Bureau of Narcotics and Dangerous Drugs h
established a new policy for reporting thefts of narcoti
and *controlled drugs.* Victims of narcotic drug thefts mu
report the details of these thefts to this office as require
under Title 26, Section 151. 472 of the Code of Feder
Regulations (Regulations No. 5.) An accurate report
any theft of controlled drugs as defined by the Drug Abu
Control Amendments to the Federal Food, Drug and C
metic Act is also required.

A form which fulfills the legal requirements for
porting narcotic and controlled drug thefts is provided
the Bureau of Narcotics and Dangerous Drugs (BND For
106.) In addition, a comprehensive pamphlet has be
printed entitled 'Narcotic and Controlled Drug Securit
which outlines safeguarding requirements for all Class
B and X narcotics and controlled drugs. This pamph
also sets out the method for reporting drug thefts.

The "Report of Drug Theft" forms and the pamph
"Narcotic and Controlled Drug Security" are available fr
the United States Department of Justice, Bureau of N
cotics and Dangerous Drugs, Room 955 Federal Buildi
31 Hopkins Plaza, Baltimore, Maryland 21201.

How to decode the national drug code...

The National Drug Code works like this: nine digits, divided into three groups...

	Manufacturer's Identification		Drug Name and Strength		Package Size
ndc	0 0 6	-	0 1 0 5	-	6 8

The first three digits identify the manufacturer... the next four identify the drug and dosage strength... the last two indicate package size.

Thus, 006 0105 68 identifies HydroDIURIL® (Hydrochlorothiazide, MSD) Tablets, 50 mg., 100's. This full number will appear on trade cartons, labels, and direction circulars—everywhere except on the tablet itself, which is easily identified by the debossed MSD 105 (the number for HydroDIURIL 50 mg.).

Note: *Until the changeover is complete, it's possible for customers to receive medication with numbers on it one time...and without numbers another time.* You can help us by assuring them that there's no difference in the drug. And if there's anything we can do to help you serve customers better...please let us know.

We hear you.

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Division of Merck & Co., Inc., West Point, Pa. 19486
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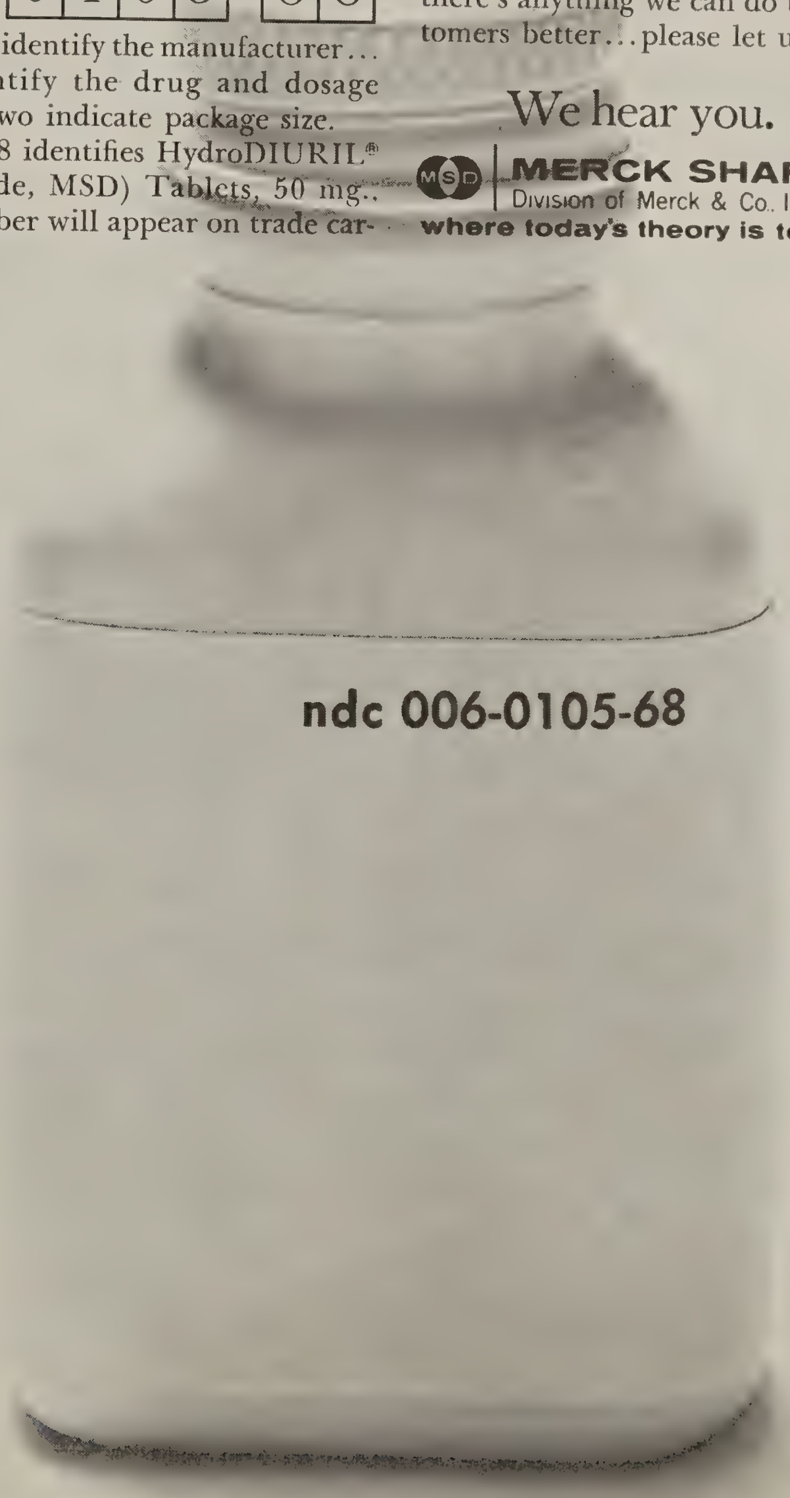

a brass tacks program t

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quantities and dates on which they were
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. THE SYMBOL OF SERVICE TO PHARMACY

Disclosing Prescription Record Information

Judicial Board American Pharmaceutical Association

June 17, 1970

ADVISORY OPINION 6-70

Is it unethical for a pharmacist to disclose prescription record information to organized research operations for statistical purposes or to recognized educators for educational purposes?

The Judicial Board is of the opinion that disclosure of information in prescription files for statistical or educational purposes is *not* in violation of Section Four or Six of the Code of Ethics or Advisory Opinion 1-70, provided certain safeguards are followed to maintain the confidential nature of these records. The information requiring protection is the identification of the prescriber and the patient in relation to the drug involved on an individual basis. It is thus, in the initial stage of tabulation of data that the ethical hazard to be guarded against exists. Where a pharmacist or other person employed by the pharmacy having regular access to the files from which the information is derived, acts as the tabulator for the statistical input no harm results.

In an educational setting, no harm will result if a pharmacist provides samples or copies of his actual prescriptions for educational purposes provided that the name of the prescriber and patient are blocked out or rendered unidentifiable.

This opinion reinforces Advisory Opinion 1-70 in requiring the pharmacist to respect the confidential and personal nature of his prescription records and not disclose such information without proper authorization in accordance with Section Six of the Code of Ethics.

This opinion indicates the proper ethical method of disclosure which satisfies both the needs of researchers and educators without compromising the confidentiality of the prescription records.

Kenneth S. Griswold, Chairman
George A. Harris
John L. Rose
George W. Grider
Donald J. Wernik

Chicago Chosen As A Site of 1973 APhA Annual Meeting

Chicago, Illinois, has been selected as the host city for the 1973 American Pharmaceutical Association annual meeting, according to an announcement by APhA Board of Trustees Chairman George D. Denmark. The dates for the 1973 meeting will be March 31-April 6.

The 1971 annual meeting is set for March 27-April 2, in San Francisco, California; and the 1972 annual meeting in Houston, Texas April 22-28. Both of these meeting sites and dates were announced earlier.

Storage Temperatures

A redefinition of the terminology used to designate storage temperatures for pharmaceuticals has been approved by the National Formulary Board. The new temperature ranges will appear in NF XIII, which is scheduled for publication in 1970. The United States Pharmacopeia has recently stated its intention to make similar revisions in the General Notices section of the next edition of the USP.

In addition to narrowing the temperature ranges which apply to various existing terms such as "cold place," "excessive heat," and "refrigerator," two terms are being introduced to the compendia along with appropriate quantitative definitions for these terms. Previously, "cool place" and "room temperature" were not defined for pharmaceutical storage purposes in the official compendia.

The complete list of storage temperature terms and the definitions, which will become effective in NF XIII, are as follows:

Cold Place—A cold place is one having a temperature not exceeding 8° (46°F.).

Refrigerator—A refrigerator is a cold place in which the temperature is held between 2° and 8° (36° and 46° F.).

Cool Place—A cool place is one having a temperature between 8° and 15° (46° and 59° F.).

Room Temperature—Room temperature is between 15° and 30° (59° and 86° F.).

Excessive Heat—The expression "excessive heat" designates temperatures above 40° (104° F.).

In announcing the NF Board action, Dr. Edward G. Feldmann, Director of the National Formulary, stated that "the stability—or rather the inherent instability—of many of today's complex and potent drugs requires more rigidly defined storage conditions. The general availability of efficient refrigeration and air-conditioning equipment now makes it possible to provide more carefully controlled storage temperatures for pharmaceutical products at all levels of drug distribution. The NF Board considered that these revisions would provide much needed preciseness and would bring the respective definitions into greater accord with present-day usage and practice."

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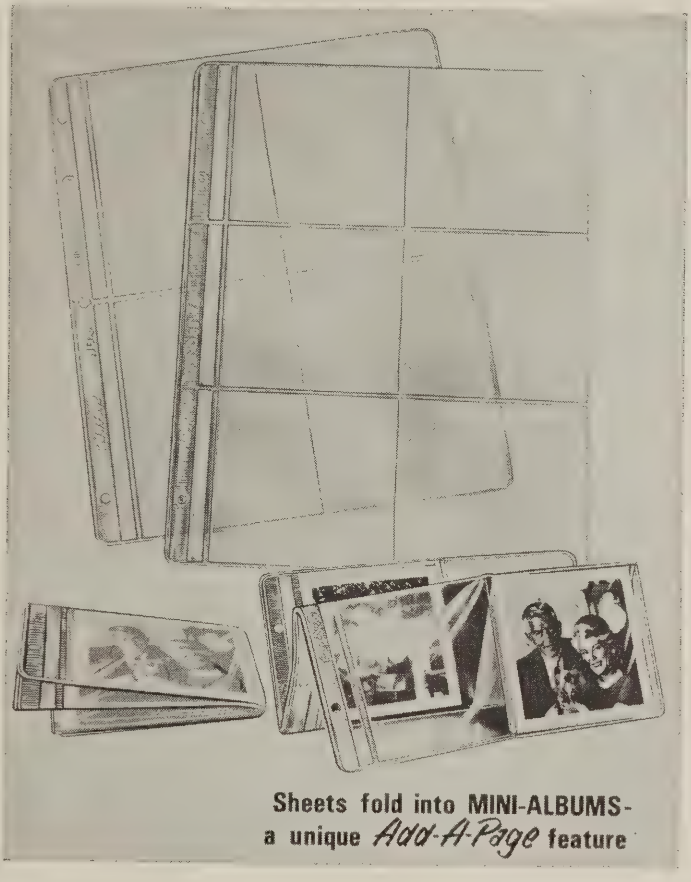

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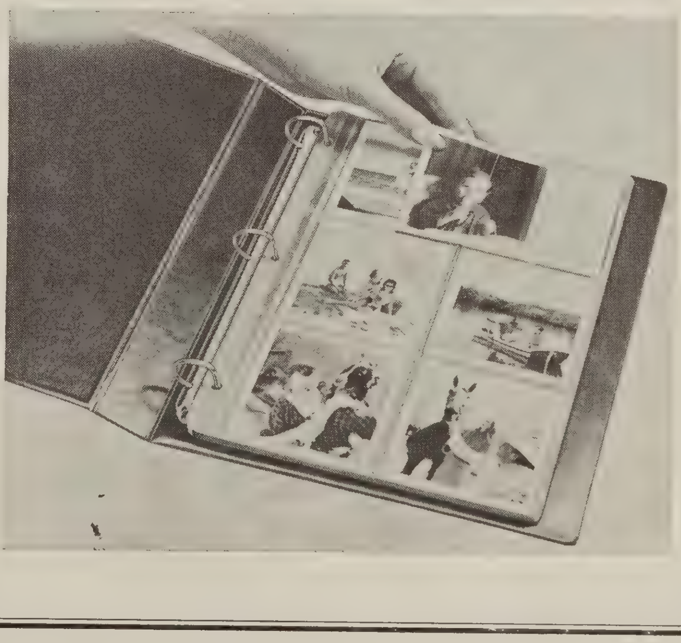


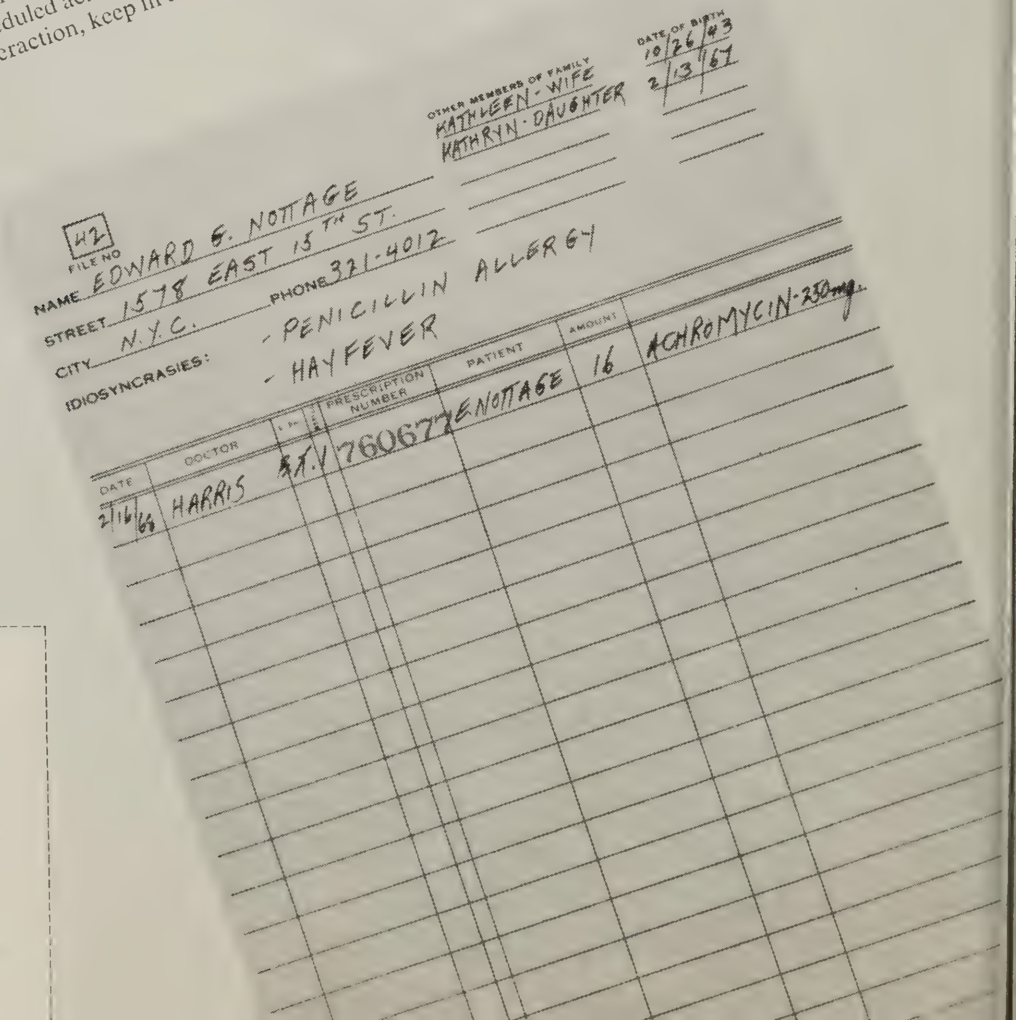
DRUG INTERACTION:

only you can know who is taking what with what!

As a pharmacist, you are the one most qualified to explain the intricacies of drug interaction not only to your customers—but to all your professional associates in the health care field. You alone have the background for this task.

But even a pharmacist may be at a loss to help his customers unless he has readily at hand the necessary information about which patients are taking which drugs. That's the reason why Lederle will mail to you at your request a sample of a commercially available Family Record Form typical of many in use today. (Simply use the coupon below.) Only with records like these is a pharmacist prepared to advise in individual problems of drug interaction.

Because Lederle is vitally interested in broadening knowledge about this important subject, we have inaugurated a program of Drug Interaction Symposia in collaboration with Schools of Pharmacy, Pharmaceutical Associations and Medical Societies. Two symposia have been held—in Hartford, Connecticut and Binghamton, New York—and others are being scheduled across the country. To keep in touch with developments in Drug Interaction, keep in touch with Lederle.



42
FILE NO
NAME EDWARD G. NOTTAGE
STREET 1578 EAST 15TH ST.
CITY N.Y.C. PHONE 321-4012
IDIOSYNCRASIES: - PENICILLIN ALLERGY
- HAYFEVER

OTHER MEMBERS OF FAMILY	DATE OF BIRTH
KATHLEEN - WIFE	10/26/43
KATHRYN - DAUGHTER	2/13/67

DATE	DOCTOR			PRESCRIPTION NUMBER	PATIENT	AMOUNT	
2/16/68	HARRIS	R	✓	760677	E NOTTAGE	16	ACHROMYCIN-250mg.

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lease send me a sample of the Family Record Form.

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ITY ________ STATE ________ ZIP ________

Francke To Receive 1970 Remington Medal

Don E. Francke has been named recipient of the 1970 Remington Honor Medal of the American Pharmaceutical Association, one of the highest awards in pharmacy, according to an announcement by Arthur G. Zupko, Secretary, Remington Honor Medal Committee.

Dr. Francke becomes the 44th Remington Medalist chosen since the award was conceived in 1918 by the late Hugo H. Schaefer in memory of Joseph P. Remington. The judging committee consists of APhA Past Presidents, and the award is made on the basis of individual service to American pharmacy.

Presentation will be made *Tuesday, December 1, 1970,* at the Remington Medal Dinner in the Roosevelt Hotel, New York City. The New York Chapter of the APhA sponosors the award.

In announcing Dr. Francke's selection, Dr. Zupko cited his "many long years of service and outstanding performance in the fields of hospital pharmacy, journalism and the development of better national and international pharmaceutical association relationships. For over two decades, Don Francke has devoted his tremendous energy toward these areas and his accomplishments make him indeed a worthy recipient of the Remington Medal for 1970."

Dr. Francke, Past President of both APhA (1951-52) and ASHP (1943-46), received his Bachelor of Science degree in Pharmacy in 1936 from the University of Michigan College of Pharmacy and his Master of Science degree in Pharmaceutical Chemistry in 1948 from the University's Graduate School. He served as Director, Pharmacy Service, University of Michigan Medical Center from 1944 to 1963 and was Associate Professor of Pharmacy at the College of Pharmacy from 1962-63. He received Honorary Doctor of Science degrees from Purdue University in 1952 and from the University of Michigan in 1967.

He is presently Professor and Chairman, Department of Hospital Pharmacy, University of Cincinnati College of Pharmacy; Director, Institute for Studies in Hospital Pharmacy at the College; and Director, Pharmacy Service, Cincinnati General Hospital.

He is Editor and Publisher of *Drug Intelligence and Clinical Pharmacy;* Editor of the *Drug Information Bulletin;* and former Editor of the *American Journal of Hospital Pharmacy,* the *International Pharmaceutical Abstracts* and the *American Hospital Formulary Service.* The latter three are publications of the American Society of Hospital Pharmacists. Dr. Francke served as Director of ASHP's Department of Scientific Services from 1963 to 1966.

He is President of the Drug Information Association s well as Chairman of the Pharmaceutical Sciences Section f the American Association for the Advancement of Science. le serves as Pharmacy Consultant to the World Health rganization and President of the Press and Documentation ection, International Pharmaceutical Federation.

His previous awards include the Harvey A. K. Whitney ecture Award and the J. Leon Lascoff Memorial Award. uthor, co-author and editor of a half dozen books, he has ritten almost 200 articles and editorials for various pub-ations.

Medicaid Prescription Preauthorization Rule

The following is from a memorandum to all local Health offices from John W. Morris, Chief, Division of Medical Services:

Section —0406 of the Regulations governing Pharmacy Services (43N04) reads in part as follows:

—0406 Preauthorized Items

Prescriptions with a total cost in excess of $10.00

In an effort to clarify the above statement, and to stabilize the number of prescriptions requiring preauthorization, the term "total cost" is interpreted to mean "ingredient cost." Consequently, prescriptions for drugs with an ingredient cost up to $10 will not require preauthorization. Prescriptions for drugs with an ingredient cost of $10.01 or more will require preauthorization.

Call at 383-3010, ext. 8871 if there are any questions concerning this matter.

HIGH SCHOOLERS
R.L. Swan, Jr.

Get Them Interested In The Study of Pharmacy

We used to make gold-plated pills

We did from 1913 into the mid-Twenties. They were rolled on this gold leaf to pick up a fine golden luster.

We don't do it now.

Today, we concentrate on putting the quality on the inside, where you and the doctor and the patient want it.

The name Upjohn is on the outside.

That says it just as well.

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USE YOUR COLLECTION SERVICE!

We'll never know or understand why smart business managers pay out hard-earned money for something, then set t aside and never use it.

For example, in checking our records recently we found hat many members who installed the Association's Collec-ion Service have never bothered to send in accounts to be ollected. Sadly, some of these same members may be say-ng the Service is no good.

We agree! It will NOT collect one dime for you if you on't put it to use. IT CANNOT WORK FOR YOU IN OUR DESK DRAWER!

If you have the Service, USE IT! If you have neglected send it some reasonably good accounts for collection ecently, get out the book and give the Service another hance. If you don't have the Service, call the MPhA office t 727-0746 or drop a note to 650 W. Lombard Street, Bal-more, Maryland 21201.

Lilly Offers Financial Analysis Service

"This year marks the thirty-eighth consecutive one f operation for the Service," Slavin continued "Through mparative analysis with averages of similar pharmacies, e financial soundness of any operation can be evaluated curately."

Individual financial data are computerized, reviewed y staff analysts, typed and mailed within thirty days of ceipt. Each report contains a thorough discussion of the ofit and loss statement and the balance sheet, comparing e averages of pharmacies of similar sales volume and escription activity.

Benefits of Analysis

Once aware of potential problem areas, the pharmacist in a position to correct them. When indicated, the report cludes attachments that contain further discussion on a rticular area and ideas for improvement. An additional nefit to pharmacy provided by the Lilly Analysis Service the publication of the annual *Lilly Digest*. The *Digest* a summary of the individual statistics submitted during previous year. In this way, detailed data on community pharmacy are readily available for use by practicing pharmacists and those interested in the profession.

The Lilly Analysis Service is offered free to all community pharmacist-owners as a free service, and the data are kept strictly confidential. You can participate by mailing your financial statements to the Lilly Analysis Service, Eli Lilly and Company, P.O. Box 814, Indianapolis, Indiana 46206.

RACISM – AN ILLNESS

"Racism is an illness that affects virtually everyone in the United States," declared Dr. Chester Pearce, professor of psychiatry and education at Harvard University and Medical School, at a talk before members of the staff of the University of Maryland Psychiatric Institute and the Inner City Community Mental Health Program.

Dr. Pearce, chairman of the committee of black psychiatrists of the American Psychiatric Association, spoke on the subject of "Education and Propaganda." As guest speaker and special consultant, Dr. Pearce discussed racism as a public health problem, to be treated on a mass basis "like vaccinating the population."

"Racism is a lethal disease," Dr. Pearce said, "and not just when it involves lynching or brutalizing." As an example of the more subtle way in which it is lethal, Dr. Pearce cited the shorter life expectancy of blacks. Schools in the black ghettos have succeeded, Dr. Pearce maintained. Through a process which he referred to as "re-inducation" they have turned black people inward, stifling their imaginations and their aspirations and thereby foreclosing hope. According to Dr. Pearce, generations of docile, accepting black people indicate the extent of the success of the schools.

Sales-Time Formula Must Be Tempered

According to the Juran Model, most widely accepted principle of sales-time allocation, a company can all but count on the largest 15% of its customers providing 65% of sales. The next highest 20% will usually account for 20% of sales; and the lowest 65,% for 15% of business. The salesman using this formula as a basis for dividing up his sales time, however, should also consider other factors, including the profitability of the sales, the customers' service requirements and the potential for the coming year.

—*The Electrical Distributor*

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Early Pharmacy In The Baltimore Campus Area

(UNIVERSITY OF MARYLAND)

by

B. F. Allen

Baltimore was laid out and incorporated in 1730, at which time it had only about 12 houses and 100 people. The first drugstore was established by Dr. William Lyon in 1746 at Baltimore and Calvert streets (Baltimore street was originally Long street and later Market streets). The second shop where drugs were available was opened by Dr. John Boyd 20 years later, the town by then had increased to 350 houses and 3500 people.

In 1767, Baltimore had 10 medical doctors and many of them operated drugstores in connection with their practice. Sometime later, because of uncertain world conditions, well trained pharmacists arrived in the city and stablished apothecary shops. For example, French refugees ame to Baltimore because of the San Domingo Massacre of 1793. They had previously escaped from France because of Napoleon and other European troubles. (The homes around Saint Mary's Seminary on North Paca street just above Franklin street are a part of the original French settlement ear Baltimore in 1791 and the area today is known as eton Hill).

Edouard Ducatel might be regarded as the father of harmacy in Baltimore. He was a French refugee, educated t the Ecole de Paris and well-trained in pharmacy. He estab- shed himself in business in 1796, as a chemist and druggist, t 26 West Baltimore street. He conducted for 40 years, ndoubtedly, the most professional drugstore up to his eriod, where scores of young men learned the science of he art, and became sufficiently equipped to enter upon the udy of medicine, or the practice of pharmacy under their wn names.

Jules Timolean Ducatel, the eldest son of the prominent rench pharmacist, received an academic training at Saint ary's College of Baltimore, 600 block North Paca street, nd then entered his father's store. (Saint Mary's Seminary n Paca street has occupied the site since 1791. Originally, aint Mary's included a general college open to all denomi- ations, but this was eliminated in 1852 when Loyola Col- ege opened in two private houses on Holliday street, where he City Hall Plaza is now located). But this employment id not prove congenial, and for twelve months (1816) he as in business in Havana. Later, his father sent him to aris to complete his education. He spent four years there, rom 1818 to 1822. To utilize his scientific attainments, his rst engagement was as Professor of Natural Philosophy in he Mechanics' Institute. He next obtained the chair of hemistry and Geology in the Faculty of Arts and Sciences the University of Maryland. In 1831, he was with great unanimity and against most eminent competitors elected as Professor of Chemistry on the Medical Faculty. He held this chair until 1837, when he voluntarily resigned it.

About 1840, in order that residential sections of the city might be accommodated more easily, the drugstores began to locate on parallel and lateral streets such as Franklin, Saratoga, Lexington, Fayette, Pratt, Greene, Eutaw, Howard, Charles, Gay, and Broadway. In 1841, there were 77 drugstores in Baltimore, with a city population of approximately 100,000. By 1877, Baltimore street was considered the main retail artery along which practically every block had a drug store.

Many of the stores were located near the markets so that people could obtain very easily both drug supplies and food. Northward from the Baltimore campus was Lexington Market dating back to 1803, when its first building was erected. A few blocks Westward from the campus was Hollins Market also dating back for many years (H. L. Mencken at one time belonged to the Hollins Market boy's gang).

As early as 1874, a famous drugstore of the old West End was at the northwest corner of Baltimore and Greene streets. The building housing the apothecary shop was a large three-story brick structure. The pharmacy was an attractive place, with big urn-like bottles filled with red and green liquid which ornamented the windows.

The Annual Circular of the Maryland College of Pharmacy, for the session of 1878-1879, advised students upon their arrival in the city to apply to W. H. Osborn, northwest corner of Greene and Baltimore streets, who would assist them in forming their relation with drugstores, and give them any further information desired.

William H. Osborn was second vice-president of the Maryland College of Pharmacy from 1877 to 1881, and treasurer from 1881 to 1882. He managed the drugstore known as E. H. Perkins and Company, at the Baltimore and Greene location.

One of the requisites for graduation from the College of Pharmacy was an apprenticeship of 4 years to the apothecary business. The Annual Circulars of the College for the sessions beginning with 1873 and ending with 1877 stated a letter was required from the employer to the Dean certifying the length of apprenticeship (this is the first mention of a dean in the college).

The circulars of 1873 to 1876 also advised students upon their arrival in the city to call upon the Dean, Dr. J. Brown Baxley, southeast corner Howard and Franklin streets, who was to furnish them with a list of desirable boarding houses and other information (this is the first reference to an individual as a dean in the college).

A continuing Article, Part I was published in the *Maryland armacist,* August 1966, Part II in June 1968, and Part III in the bruary 1969 issue. The author is Associate Professor of Pharmacy, iversity of Maryland.

J. Brown Baxley (1814-1896) struggled effectively for re-establishment of M.C.P. (a widely used abbreviation for Maryland College of Pharmacy) in 1857, served as its treasurer from 1870 to 1876 and was also on the Board of Examiners (conducted oral examinations on the several branches of pharmaceutical study as a requisite for graduation) for several years. In 1876, listed among the graduates from M.C.P. was J. Brown Baxley, Jr.

The following interesting advertisement appeared in 1870: J. Brown Baxley, apothecary, southeast corner Howard and Franklin streets, and J. Brown Baxley and Company, southwest corner Franklin and Calvert streets. The attention of physicians and pharmaceutists is called to Elixir of Poke Berries as a most effectual remedy in the treatment of gout, rheumatism and neuralgia. Their patronage, respectfully solicited for this preparation since it has never been known to produce any unpleasant symptoms. Also publicized was a Hair Restorer to turn gray hair to its original color, and the proprietor guaranteed that there is no preparation of lead, or other deleterious substance injurious to the hair or the constitution, in its composition.

The Annual Circular, 1872-73, refers to just Dr. J. Brown Baxley and in 1876-77 to Louis Dohme, southwest corner Howard and Pratt streets for advising students upon their arrivals in Baltimore. In the 1877-78 session circular it was directed that the letter certifying apprenticeship be forwarded to the treasurer of the College.

E. H. Perkins and Company, Baltimore and Greene streets, was the preceptor for several students from M.C.P.; in 1874, John H. Baughman; 1879, William M. Arnold; 1880, Conrad Wich; 1881, John C. Groome and Conrad Wich. In 1887, the Baltimore and Greene store was listed as S. N. Appleby and Company and acted as the preceptor for Jacob Lee Walz of Virginia. The Maryland Board of Pharmacy, in 1925, listed Samuel N. Appleby as being deceased.

The best known apprentice from the Baltimore and Greene drugstore was Conrad L. Wich (1861-1940) who was born in Bavaria and emigrated to Baltimore with his parents at the age of eight. His early education began at the German Parochial School, Lombard and Catherine streets (this street intersection exists today in the old western section of the city between the 2400 and 2500 blocks of West Lombard street). He then attended the public schools, first a grammar school and then Baltimore City College.

The City College building (a male high school) was erected in 1875 at the southwest corner of Howard and Center streets, just north of Franklin street. A next door neighbor on the northside was the youthful Johns Hopkins University. The neighbor on the southside was a theatre called "Academy of Music" where the Maryland College of Pharmacy held many graduation exercises.

A large section of the old B.C.C. (widely used abbreviation for Baltimore City College) building collapsed during the excavation under Howard street for the Baltimore and Ohio Railroad tunnel from Camden Station on the south to Mount Royal Station (now occupied by the Maryland Institute) in the north. A new building was started in 1895 and completed in 1899. This particular structure is standing today and used as a high school.

The Entrance Examiner for the session 1915-16 was Professor Wilbur F. Smith, principal of the Baltimore City College, Howard and Center (Centre) streets. (Admission to the course in pharmacy, at the Lombard and Greene street institution was by certificate issued by the Entrance Examiner).

Mr. Wich decided to study pharmacy after the age of sixteen and began as an apprentice in the drug store of Henry Mittnacht at Lafayette and Pennsylvania avenues. In about a year he changed to E. H. Perkins at Baltimore and Greene streets, due to the fact this location was closer to home, and in those days one had to walk to work and have the shop open at 6 a. m. At this time, he attended the Maryland College of Pharmacy (then located on Aisquith street near Fayette) during the sessions of 1880-81 and 1881-82. He graduated in 1882 and received third prize in a class of seventeen members. At that time, appropriate college prizes, rated according to merit, were presented a each annual commencement to the three successful candidates for graduation who acquitted themselves most creditably at the examination conducted by the Board of Examiners. The degree conferred at graduation was that o Graduate of Pharmacy (Ph.G.).

In 1883, Mr. Wich was employed to manage the store o Emile Sinsz (1869 M.C.P. graduate) located at Stricke and Laurens streets. In 1886, he purchased this store an was actively engaged at the same location as late as 1932

[Note:] Mr. Ross P. Campbell, 2625 N. Calvert St., Baltimore, Md., recently reported that the Baltimore and Greene street pharmacy was founded in 1842 by Elisha H. Perkins.

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Nathan I. Gruz, Editor
Maryland Pharmacist
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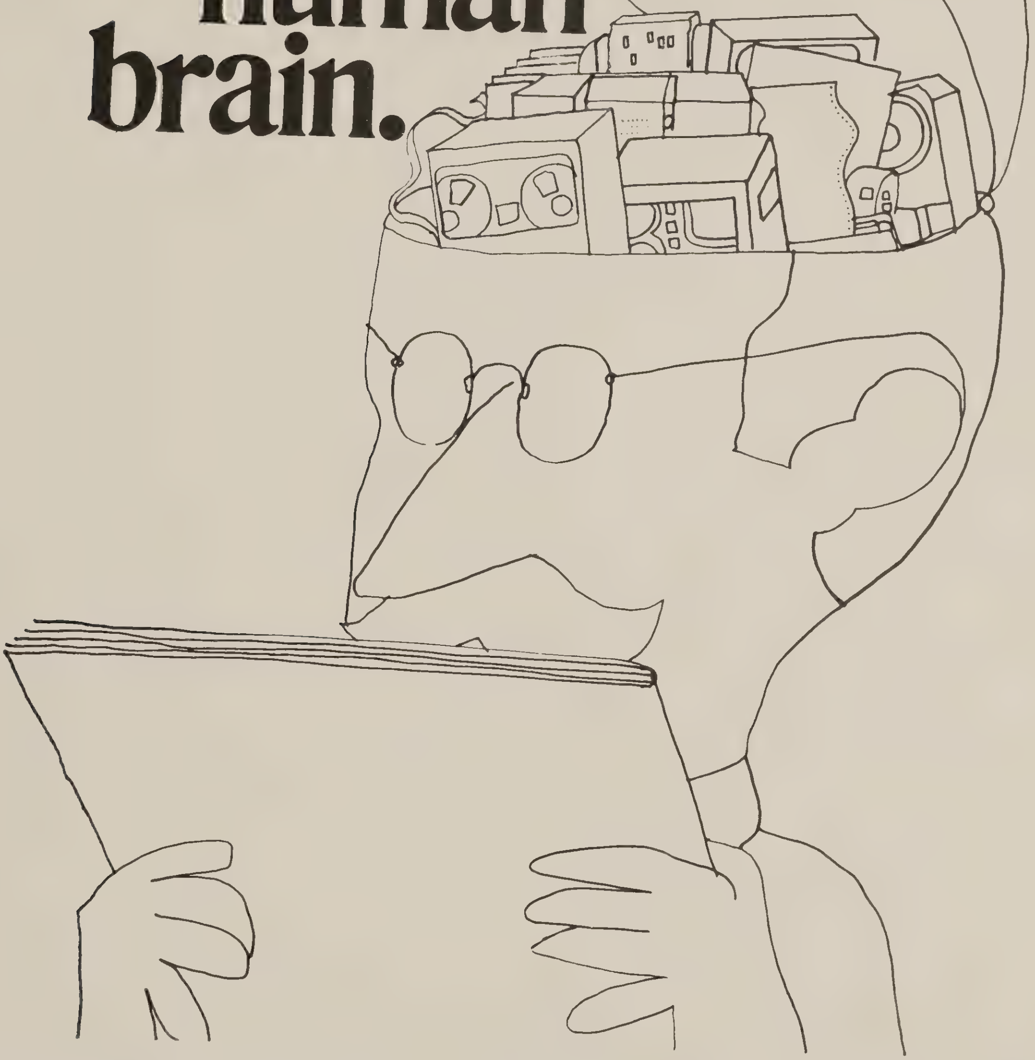

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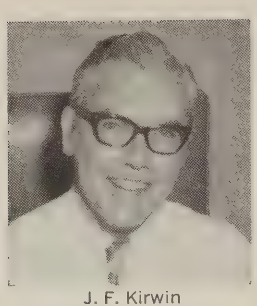
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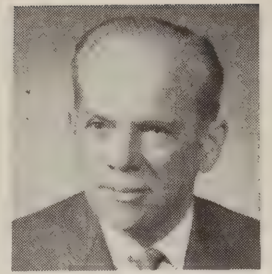
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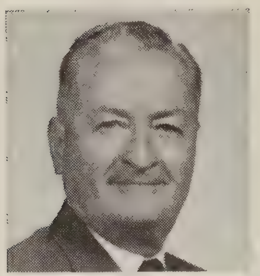
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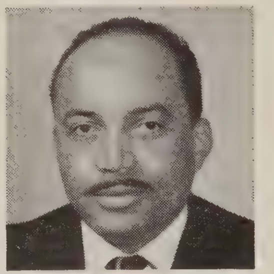
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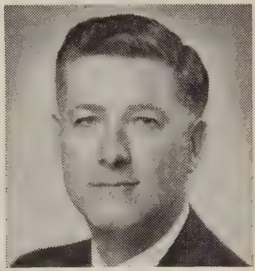
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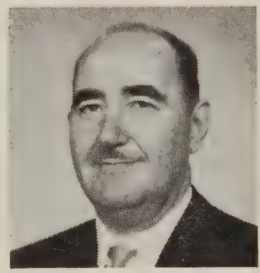
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1882

the maryland pharmacist

Maryland Pharmaceutical Association Highlight

Summit Meeting

Governor Marvin Mandel (center) meets with President I. Earl Kerpelman (right) and Executive Secretary Nathan I. Gruz (left).

Volume 46 JULY 1970 Number 7

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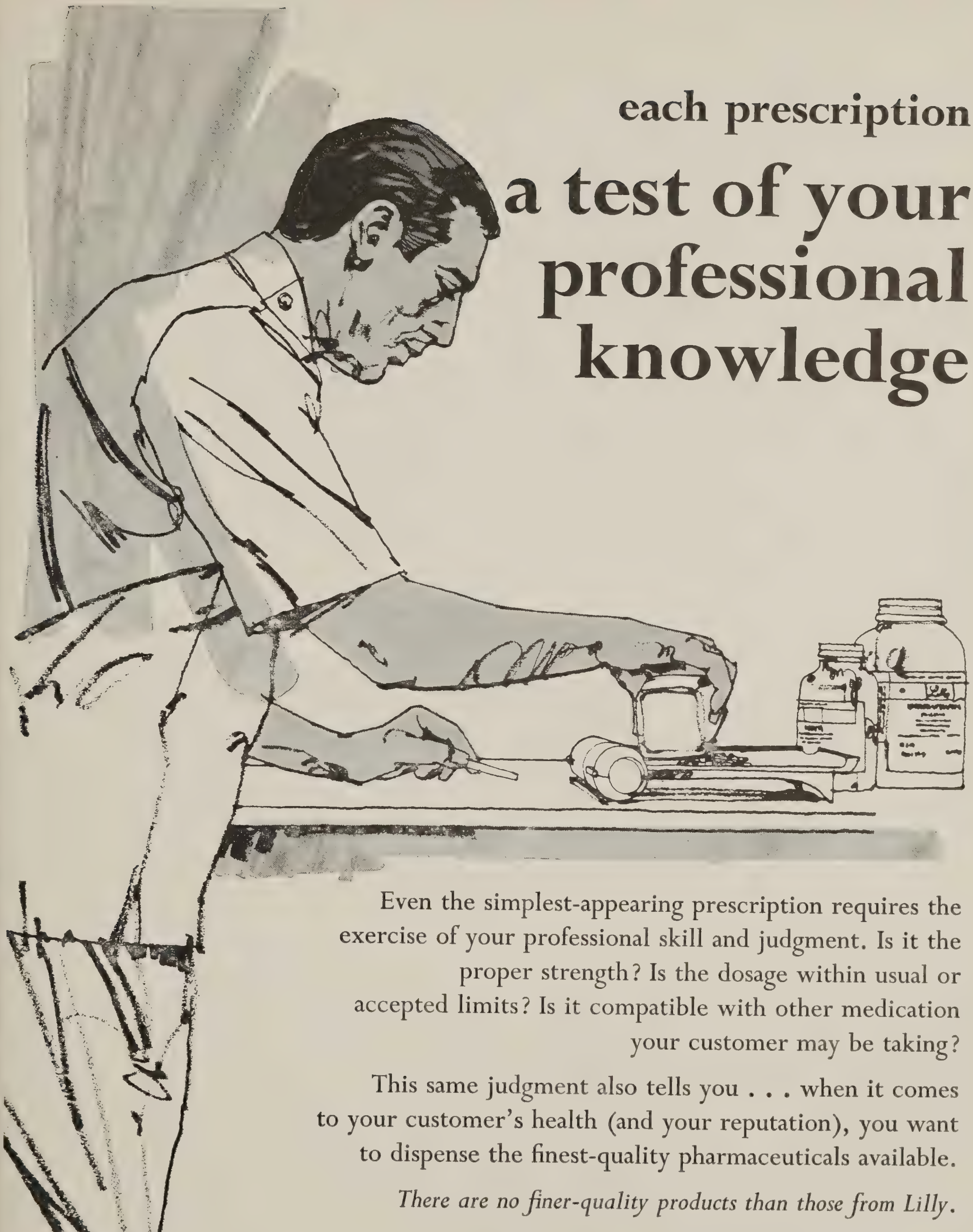

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The Maryland Pharmacist

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650 WEST LOMBARD STREET
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BALTIMORE, MARYLAND 21201

MEMBER
STATE PHARMACEUTICAL EDITORIAL ASSOCIATION
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Report of Executive Secretary

Nathan I. Gruz

1969-70

Delivered at the 88th Annual Meeting of the Maryland Pharmaceutical Association, Second Business Session, July 14, 1970, Shelburne Hotel, Atlantic City, New Jersey. Mr. President, Members of the Maryland Pharmaceutical Association, and Friends:

This year—1970—marks the beginning of a new decade, but I believe, significantly for the Maryland Pharmaceutical Association, the opportunity to move from a position rooted in many stifling traditions and patterns of thought.

In this, my ninth report to you as Executive Secretary, I would like to indicate within the limits of my allotted time something of what we have accomplished during the past year and what is even more essential, some of the factors influencing pharmacy and what we must direct our attention to in the coming months and years.

The reports presented at our First Session provided a summation of some of our many programs. You heard how our chairmen outlined the tremendous effort and time devoted to legislation, Medicaid, professional relations, seminars, public relations, School of Pharmacy, Board of Pharmacy, finances and other matters.

In the area of legislation, we will have to develop effective self-discipline machinery which will involve the profession through the Maryland Pharmaceutical Association, in the maintenance of the highest standards of ethical and professional conduct. We must see that those in our midst who are guilty of violations are appropriately dealt with for the protection of the public health as well as the good name of the majority in pharmacy.

Steps must be taken to assure the public of proper safeguards in the distribution and use of all medication-prescription and non-prescription.

All pharmacists who are not the proprietors of the pharmacies where they work must assume full professional responsibility for the practices in those establishments. The Board of Pharmacy has made it clear that this is the legal responsibility of these pharmacists.

As to Medicaid and other third party plans, an MPhA "Peer Review" mechanism must be operative to assure proper administration and utilization controls. We must expand our efforts to document the need for equitable reimbursement in all these plans. The increase under the Medicaid program to $1.75, of CHAMPUS to $1.85 and of Blue Cross to $1.95 are the results of these necessary activities.

Backing up all these programs must be understanding of the legislative representation that is required. During the past few years, most of this has devolved on your Executive Secretary. In addition, PHARMPAC—the Pharmacists Political Action Committee—was organized by concerned pharmacists as an independent activity. PHARMPAC played an important part in 1966 and is now embarking on an even more ambitious role. We are extremel fortunate to have two outstanding pharmacists running fo office. I refer to Don Fedder for the House of Delegates i Baltimore County and Arnold ("Skip") Amass for Stat Senate from Carroll and Frederick Counties. It is in you interest to do everything possible by action, talk and fund to assure their support.

Let me emphasize that we have much to be proud o in the areas of legislation, medicaid, continuing educatio and third-party payment plans, to mention just a few. W have, of course, a great deal more remaining to accomplish in these and other areas.

As has been said many times before, but must unfortunately be repeated, we are severely handicapped by ou limited resources, which are a result of lack of suppo from many pharmacists who are not members. In additio there are many suppliers in the allied industries who d not recognize that the Maryland Pharmaceutical Associ tion is essential to the viability of pharmacy in Marylan "Sustaining Memberships" were set up to place the rel tionship between Maryland Pharmaceutical Association an wholesalers and manufacturers on a business-like basi That is, we provide certain services and advance our con mon interests and, therefore, all involved-pharmacists an industry—must help carry the load.

What are some of the other concerns which we mu address ourselves to? Where should our emphasis be? Ho shall we reorder our priorities?

Internally, we must implement a House of Delegat structure to provide for a broad base of representation f a greater number of pharmacists to participate in associ tion policy-making.

In addition, we must develop a committee syste which will utilize a "Reference Committee" procedure assure thorough consideration of complex issues and pe mit adequate opportunity for discussion by the memb ship.

We must elaborate our membership solicitation tec niques so that every non-member pharmacist is contact personally in every part of the state.

Affiliation with the American Pharmaceutical Assoc tion is being recommended by the special study comm tee at this Annual Meeting. Hopefully this will be consu mated after thorough consideration by the general me bership. This ties in with a membership campaign by sharing of costs for field personnel by American Pharm ceutical Association.

The Intra-Professional Relations Committee concer with employer-employee problems must be activated w out delay as an area of Association service.

I believe there is increasing understanding betw institutional and community pharmacists and it is refle in better liaison and cooperation with the Maryland ciety of Hospital Pharmacists.

We are now involved in a tripartite effort with the School of Pharmacy and the Board of Pharmacy to replace the practical experience requirement with clinical experience within the academic curriculum and academic year. To this end an organized and supervised pilot program for senior students in clinical, community and hospital pharmacy areas under approved preceptors has been inaugurated.

Our Annual Convention obviously must be streamlined and returned to a Maryland site in the Baltimore-Washington area or even Western Maryland or Ocean City.

The response to Continuing Education sponsored by both the University of Maryland and the Maryland Pharmaceutical Association has been excellent. However, only a minority of our profession is participating and serious hought should be given to proposals for a mandatory system.

During the coming year the Maryland Pharmaceutical Foundation under Dr. Samuel Fox will call on all in our profession and our friends in the industry so that our program for the Swain Model Pharmacy, the Cole Pharmacy Museum, and the Kelly Memorial Building can be completed.

Crucial to accomplishing our goals is improved communications to our members and all in pharmacy. To this nd we will be having assistance in publishing *The Maryand Pharmacist* beginning with the July issue.

As we ponder all the matters we have been involved in his past year, all the issues before us today and the problems we must address ourselves to in the months and years head, let us look for a moment at what is happening to ow and where pharmaceutical services will be provided nd what these services will be like.

Institutional forms of pharmacy service in hospitals, linics and dispensaries is becoming a growing percentage f total pharmacy service. In addition, in the community harmacy sector chain and supermarket pharmacies are ssuming a rapidly increasing percentage of the total community or non-institutional prescription practice. At the ame time, independent pharmacies are showing an ever-ncreasing growth in professional services as a percentage f their total volume.

What is the emerging role of the pharmacist? I think e will learn a little about this from our speaker on Naonal Health Insurance and panelists on clinical pharmacy our annual meeting.

Let me quote from International Pharmaceutical Abracts for 30 March 1970 in reference to what Dean Linood F. Tice has written:

> "Today hospital pharmacy is setting the standard for the whole profession and it is hospital practice and the philosophy surrounding it which must be accepted by all pharmacists if the profession is to go forward on a united front.
>
> If a student has studied clinical pharmacy and goes into community practice, he hopefully will see more clearly his role as a health professional.
>
> In the emerging pattern of health care, the public interest will require a closely coordinated system wherein pharmacists at all levels must cooperate in the patient's interest. The author discusses ways the pharmacist can be utilized once he is freed from mechanical tedium by use of machines and technicians.
>
> As pharmacists render greater service where the need exists, they will be accepted and embraced by other professionals and, together as a team, they may succeed in meeting public expectations and demands."

Joseph Oddis, Executive Secretary of the American Society of Hospital Pharmacists, asserted this year:

> "One social force which is accelerating the trend toward institution-based health care is the migration of the independent, solo health practitioner, along with his affluent patients, to suburbia, leaving the inner city and rural America deficient in the availability of health care services. This deficiency will never be solved on a solo practice basis—some form of institutional or group practice is the only answer. In short, health care will revolve more and more around the institutional setting regardless of the number of pharmacists who will be considered institutional practitioners as opposed to community practitioners."

Professionally oriented pharmacists will find satisfying roles in providing health services in the coming decade. The School of Pharmacy will have a major part in qualifying present and future pharmacists to discharge new and greater responsibilities in all facets of pharmacy practice, as well as in broader areas of community health care and public health.

For those who must or prefer to continue in traditional patterns of practice, there are merchandising, distributing and wholesaling organizations to provide new forms of assistance and guidance. The alert, aggressive, imaginative pharmacist still has opportunities to initiate enterprises and survive in both professionally oriented and where necessary other types of pharmacies.

With the outlook facing us that a majority of the prescriptions will be provided in third-party payment plans within 5 years and with National Health Insurance an almost certain reality within three years, pharmacists can expect a tremendous explosion of opportunities for their professional services in both community and institutional environments.

In closing, I think we should all pay tribute to a dedicated pharmacist, I. Earl Kerpelman of Salisbury, who sacrificed a great deal on behalf of all in pharmacy, in serving as President of Maryland Pharmaceutical Association this past year. He willingly traveled, sometimes several times a week, back and forth to Balimore and other parts of the State. He is devoted to advance pharmacy and its service to the public. Many thanks, Earl, for all you have done for pharmacy and me personally, during these challenging months.

To the other officers, committee chairmen, members, and my staff who contributed so vitally to the work of the Association, my sincere thanks.

The support and understanding of many of you is what enabled me to accomplish what I hope has been of some value toward securing our goals: advancing the profession of pharmacy in Maryland and our nation so that more effective health services will be available to all who need them.

President's Message

I. Earl Kerpelman

Maryland Pharmaceutical Association
88th Annual Convention — Shelburne Hotel
Atlantic City, New Jersey
July 12 - 16, 1970
Second Session, July 14, 1970

My term of office began on the afternoon of Thursday, July 17, 1969 with an exciting and precedent breaking session of the Annual Convention Meeting.

Two astronauts were streaking for man's first landing on the moon. I was elected President and that night I had the rare privilege of witnessing two of my classmates, Charles E. Spigelmire and Irving I. Cohen, being honored by this Association. Certainly these events were omens of good things to come.

This past year, as your President, has been an exciting and rewarding experience for me. It was my privilege to meet many leaders in pharmacy and many friends in pharmacy. This is our 88th Annual Convention. It has been a great year marked with considerable results in legislation and in membership.

An organization of the size of the Maryland Pharmaceutical Association cannot be managed by one man alone nor by two or three. It requires a concerted effort of many to accomplish the job. In this team effort, I was very fortunate because the officers, executive committee members and committee chairmen gave generously of themselves. I was impressed with the sincerity of their cooperation, their eagerness, their dedication and their common effort towards the betterment of the Maryland Pharmaceutical Association. Through these combined efforts we have accomplished much.

Among our accomplishments allow me to proudly enumerate, as follows:

> We received the tax exemption status for the Maryland Pharmaceutical Foundation.
>
> The fee for Medical Assistance Prescriptions has been increased.
>
> We defeated the effort to repeal the Maryland Fair Trade Law.
>
> We are represented in regional health planning, the Hospital Licensing Board and the Blue Cross Pharmacy Advisory Committee.
>
> We are active in the area of drug abuse education and information.
>
> We have conducted continuing education programs.
>
> The membership will have greater representation with our proposed House of Delegates set up.
>
> APhA affiliation is under serious consideration and, if completed I believe is bound to strengthen our Association.
>
> A Pharmacy Discipline Commission is being considered which is designed to advance proper professional conduct and take prompt action against offenders within our own ranks.
>
> We successfully countered the proposed legislation to place exempt narcotics in the prescription only category.
>
> The Board of Pharmacy Study Committee has made recommendations for updating legislation as it applies to the make-up of the Board.

We have accomplished much but there is much more to be accomplished. We must constantly develop the necessary facts concerning the economics of dispensing prescriptions in order to assure equitable compensation in prescription pre-payment plans. We must ever be alert to the need for pharmacy legislation and ever guard against legislative attacks on pharmacy.

Unfortunately, with the necessity for our Executive Secretary to devote an ever increasing part of his time t legislative matters, Medicaid (budget administration and payments) and many other government programs and private prescription plans, it was not possible to publish *Th Maryland Pharmacist* regularly. The Secretary must o necessity, first devote his time to our extremely importan problems and programs which cannot be delayed. I have therefore, recommended the employment of an assistant on a part-time basis, to work on our journal. His assignment is to see that the regular publication schedule is maintained. I believe that this will go a long way in meetin our requirements for good communications. Our journa can include a synopsis of our Executive Committee an other meetings, thereby informing our membership of th many activities MPhA performs for the benefit of our members, the entire profession of pharmacy and for publi health.

The Board of Pharmacy also is handicapped by th information gap. It should let the pharmacists know abou the constant and diligent efforts made for the benefit pharmacy and pharmacists. I recommend that the Board Pharmacy, either independently or through the facilities the MPhA, issue a monthly synopsis, explaining the efforts.

Another unfinished item is that of an MPhA Intr Professional Relations Committee. This is an urgent a immediate problem and should be implemented at th time.

Just as it is important for pharmacists to have a stron well financed association, so it is equally important for o suppliers that the MPhA remain a strong force. We must recognize that our welfare is also their welfare. I referring to the matter of "Sustaining Membership." "Sustaining Membership" is accomplished when a suppl contributes his share to help sustain this Association that MPhA can do the required job for both pharmaci and suppliers. This means that he has become a "Susta ing Member." According to the dictionary, "sustain" me "to keep in existence," and in this instance it means facets of pharmacy—pharmacists, wholesalers and ma facturers. They sink or swim together.

(*Continued on page* 11)

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Maryland Board of Pharmacy News . . .

Pharmacy Changes . . .

The following pharmacy changes that have not been previously reported are listed for the information of all concerned.

The following are pharmacy changes for the month of August 1969:

No Longer Operating As Pharmacies

Floms Drug Store, Herman M. Kling, 2241 E. Fayette Street, Baltimore, Maryland 21231.

W. Scott Walb & Son, Winfield A. Walb, 6002 Harford Road, Baltimore, Maryland 21214.

Macek's Pharmacy, Frank J. Macek, 1736 Aliceanna Street, Baltimore, Maryland 21231.

Changes Of Address, Ownership, Etc.

L & M Pharmacy, Frank F. Cwynar, Jr., President (Formerly owned by H. Leavey, President), 703 Ald Annapolis Road, Glen Burnie, Maryland 21061.

City Pharmacy, Albert M. Newman (Change from partnership to individual ownership), 309 N. Union Avenue, Havre de Grace, Maryland 21078.

Ford's Frostburg Pharmacy, Inc., Clarence L. Sandene, President (formerly located at 19-21 East Main Street, Marlin Cargill, President), 11 West Main Street, Frostburg, Maryland 21532.

Ford's Pharmacy, Inc.—Cumberland, Grover D. Hott, Jr., President (Formerly owned by Marlin Cargill, President), 24C South Lee Street, Cumberland, Maryland 21502.

Prince Frederick Pharmacy, Inc., Thomas R. Palmer, President (Formerly owned by Ruth I. Toronto), P.O. Box 99, Prince Frederick Shopping Center, Prince Frederick, Maryland 20678.

White Cross, D. M. Robinson, President (Formerly Whelan of Maryland No. 1, Inc.—Philip Wise, President), Edgewater Shopping Center, 1820 Earhart Road, Baltimore, Maryland 21221.

Mercer's Pharmacy, Daniel S. Shaner (Formerly owned by Grace R. Mercer), 243 N. Market Street, Frederick, Maryland 21701.

The following are pharmacy changes for the month of September 1969:

New Pharmacy

Northern Pharmacy at Milford Mill, Martin Mintz, 4204 Milford Mill Road, Baltimore, Maryland 21208.

Pharmacy Change

Darlington Pharmacy, Inc., Arnold N. Neuburger, President (Formerly owned by William T. Foley, Jr.), Shuresville Road, Off Rt. 161, Darlington, Maryland 21034.

The following are pharmacy changes for the month of October, 1969:

New Pharmacies

Peoples Service Drugs Stores, No. 288, G. B. Burrus, President, Plaza Del Mercado, 2271 Bel Pre Road, Silver Spring, Maryland 20906.

Read's, Inc. Store No. 2, Arthur K. Solomon, President, Hollinswood Shopping Center, 2141 W. Patapsco Avenue, Baltimore, Maryland 21227.

Sentry Drug Center, Edward R. Babst, 6023 Moravia Park Drive, Baltimore, Maryland 21206.

No Longer Operating As Pharmacies

Calverton Pharmacy, Henry Levinson, 721 Poplar Grove Street, Baltimore, Maryland 21216.

Essex Drug Store, Paul Zucker, 436 Eastern Boulevard, Baltimore, Maryland 21221.

Stemmers Run Pharmacy, Samuel Gelblum, 405 Stemmers Run Road, Baltimore, Maryland 21221.

Windsor Drug Store, Richard A. Butler, 3726 Windsor Mill Road, Baltimore, Maryland 21216.

Changes In Ownership, Address, Etc.

Asbill's Pharmacy, Alfred H. Alessi, President (Change of address—formerly located at Washington and Chesapeake Avenue), 417 York Road, Towson, Maryland 21204.

Riggs Manor Pharmacy, Samuel I. Kouzel (Change from partnership to individual ownership), 6573 Ager Road, Hyattsville, Maryland 20782.

Eakles Pharmacy, Leon R. Catlett, President (Formerly Village Pharmacy, Inc.—Kenneth M. Shockman, Vice-President) 31 N. Conococheague Street, Williamsport Maryland 21795.

The following are pharmacy changes for the mont of November, 1969:

New Pharmacies

Lawson & Sons, Pharmacists, R. Sullivan & A. Lawson 6005 Landover Road, Cheverly, Maryland 20785.

Giant Pharmacy No. 205, J. B. Danzansky, President 6223-25 Baltimore National Pike, Baltimore County, Maryland 21228.

Peoples Service Drug Stores, Inc. No. 148, G. B Burrus, President, 1301 Lamberton Drive, Silver Spring Maryland 20902.

Peoples Service Drug Stores, Inc., G. B. Burrus, President, 1334 Crain Highway, South, Bowie, Maryland 2071

No Longer Operating As Pharmacies

Garwyn Pharmacy, Richard A. Butler, 2300 Garriso Boulevard, Baltimore City, Maryland 21216.

Allen's Pharmacy, C. Murray Allen, 243 Virginia Av nue, Cumberland, Maryland 21502.

Changes In Ownership, Address, Etc.

John R. Thomas, Pharmacist, John R. Thomas (Fo merly Dun-Hol Pharmacy, Walter C. Zajac), 6712 Hol bird Avenue, Baltimore City, Maryland 21222.

Rutkowski's Pharmacy, Marvin L. and C. Lois O (Change of officers—formerly D. Rutkowski and M. Oed 743 South Conkling Street, Baltimore, Maryland 21224.

Rodman's Drugs, Seymour Sattin, Pres. (Forme University Lane Drugs—Lawrence Jason, Pres.), 2510 U versity Blvd. E., Hyattsville, Maryland 20783.

Potomac Valley Pharmacy, Inc., Robert J. Mart Pres. (Formerly Lavale Rexall Drug Store—C. A. Lill President), 1068 National Highway, LaVale, Maryla 21502.

The following are the pharmacy changes for the month of December 1969:

New Pharmacies

Drug Fair No. 28, Milton L. Elsberg, 5600 Fishers Lane, Rockville, Md. 20852.

Changes In Ownership, Address, Etc.

National Pharmaceutical Service & Supply, Inc., J. Kennedy Sills, Pres. (Change of Name—formerly Pine View Garden Pharmacy), 7401 Stuart Lane, Clinton, Md. 20735.

Voshell's Pharmacy, Inc., Joseph U. Dorsch (Change of Address—old address: 3700 Edmondson Ave., Balto., Md. 21229), 3350 Wilkens Ave., Balto., Md. 21229.

The following are the pharmacy changes for the preceding month. Reported July 17, 1970.

New Pharmacies

Dart Drug Corporation, Riverdale, Herbert H. Haft, President, 6250 Kenilworth Avenue, Riverdale, Maryland.

No Longer Operating As Pharmacies

Preston Pharmacy, Jerome L. Fine, President, 1301 North Charles Street, Baltimore, Maryland 21201.

Medford Pharmacy, Arnold Siegel, President, 5810 Eastern Avenue, Baltimore, Maryland 21224.

Village Pharmacies, Inc., Kenneth M. Shockman, President, 363 South Cleveland, Hagerstown, Maryland.

Village Pharmacies, Inc., Kenneth M. Shockman, President, 31 North Conococheague, Williamsport, Maryland.

Village Pharmacies, Inc., Kenneth M. Shockman, President, 16 North Jonathan, Hagerstown, Maryland.

Changes In Ownership, Address, Etc.

Welsh Pharmacy, Resort Enterprises, Inc., 22nd and hiladelphia Avenue, Ocean City, Maryland 21842.

Meyer's Pharmacy, Inc., Harmond Amernick, Presilent, 2101 West North Avenue, Baltimore, Maryland 21217.

President's Message

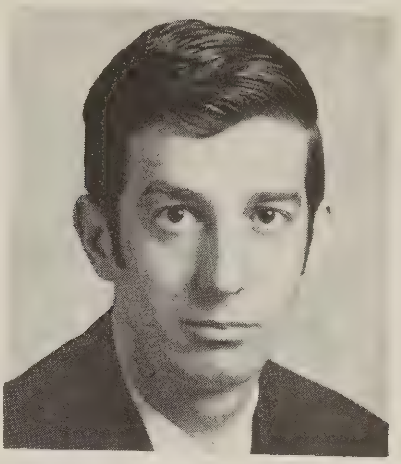
(Continued from page 8)

At this time, I want to thank the gentlemen of TAMPA nd the Ladies of LAMPA for their cooperation and asstance. I want to thank Mrs. Margaret Huber, Mrs. Mary nne Frank and Miss Hazel Pfister for their gracious coperation and help. I want to thank Dean Kinnard and is Associates, at the School of Pharmacy for their conderation and assistance. And to all of our suppliers of rugs and sundries and confections and concoctions and libles and accessories and whatever, a great thanks for our wonderful participation.

I want to thank the Executive Secretary. This much aligned, greatly harrassed, sometime conspired against ntleman, is loaded with more problems than any one an can carry. Yet, he represented us well in the state gislature. He has been our spokesman for pharmacy presentation. He attends numerous professional meetings. e is threatened and beleagured, but somehow he keeps s cool. His advice and experience were invaluable to me. want to thank him for all his help.

Last of all, I want to thank all of you for giving me e opporunity to be your President this past year. May d bless you and our new President with health, happiss and good fortune in the coming year.

Assistant Editor Named



NORMAND A. PELISSIER

Normand A. Pelissier of Joppa, Maryland, staff pharmacist at the Union Memorial Hospital in Baltimore, has been appointed Assistant Editor of *The Maryland Pharmacist.*

Mr. Pelissier, a native of Massachusetts, received his B.S. in Pharmacy from the University of Rhode Island College of Pharmacy in 1961. He became registered in Massachusetts that year and began his career in hospital pharmacy at the Massachusetts General Hospital where he served as staff pharmacist from 1961 to 1964. In 1964, Mr. Pelissier became registered in Maryland and joined the staff of the Union Memorial Hospital.

During his nine years of hospital pharmacy practice, Mr. Pelissier has maintained an interest in community pharmacy by working on a part-time basis as a community pharmacist. He is co-author of "Guide to Intravenous Incompatibilities," a pamphlet which has received wide circulation.

Mr. Pelissier has been active in the Maryland Society of Hospital Pharmacists and is presently Secretary of that organization. He initiated publication of the "Maryland Hospital Pharmacist" newsletter of the MSHP and served as its first editor.

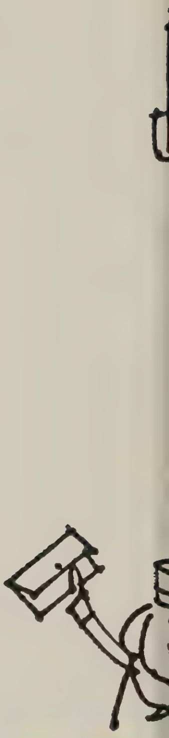
His professional affiliations include the American Pharmaceutical Association, American Society of Hospital Pharmacists, MPhA and BMPA.

Leader Drugs begins publication of Newsletter for employees

Leader Drugs has begun issuing a periodic newsletter to its employees of Leader Drugs and Sav-A-Lot Discount Stores in order to keep its employees informed of the chain's progress.

The company was started 1960 and in 9 years has grown to a chain of 4 stores during which time, the sales volume has increased over 10 times since its first year of operation. From an industry standpoint, this is considered far above the average growth for a drug chain.

Officers of the Leader Drugs chain are: President, Milton L. Hillman; Vice-President, Albert Hillman and Secretary-Treasurer, Sheldon J. Hillman.



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Hospital Pharmacy Section

Inauguration of The Hospital Pharmacy Section in The Maryland Pharmacist

A new hospital pharmacy section has been added to *The Maryland Pharmacist* beginning with this issue. Each month we will bring you news of importance in the hospital pharmacy field, reports of Maryland Society of Hospital Pharmacists activities and other information about institutional pharmacy practice. By this addition, this journal is attempting to broaden its relevancy to a greater number of pharmacists as part of a continuing effort to establish improved communication with all pharmacists in the state.

It has long been the position of the Maryland Pharmaceutical Association that it is an organization which speaks for all of Pharmacy in Maryland. By establishing a closer dialogue between community and hospital practitioners, it is hoped that both groups will become more aware of the advantages of combined and unified representation and will better their working relationships. It is only with this kind of attitude that all groups in pharmacy will achieve goals which are beneficial to all segments involved.

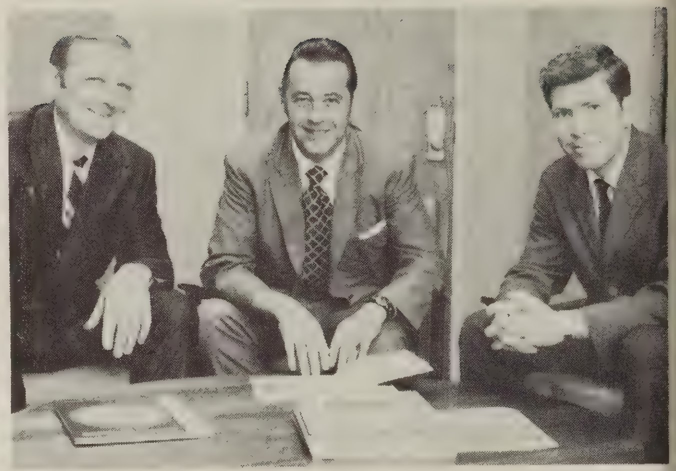
University of Maryland Announces New Pharmacy Appointments . . .

Dr. George H. Yeager, director of the University of Maryland Hospital, and Dr. William J. Kinnard, Jr., dean of the School of Pharmacy, University of Maryland at Baltimore, have announced jointly a plan to restructure and expand pharmaceutical service and educational functions in the hospital.

Dr. Peter P. Lamy, associate professor and director of the school's institutional pharmacy programs, will assume the additional duties of the direction and organization of the pharmacy services in the hospital, as well as the planning for future programs. He will also direct the institutional phase of the clinical pharmacy educational program of the School of Pharmacy.

Dr. Lamy received his B.S., M.S. and Ph.D. (Biopharmaceutics) from the Philadelphia College of Pharmacy and Science. He has been chief pharmacist 2164-1 U.S. Army Hospital, Ft. Eustis, Virginia. He was an instructor in pharmacology at the Hospital of the Woman's Medical College in Philadelphia and an instructor in pharmacy at Philadelphia College of Pharmacy and Science before he joined the faculty at Maryland.

He is a member of the American Pharmaceutical Association, the Academy of Pharmaceutical Sciences, the American Society of Hospital Pharmacists (vice chairman, Council on Scientific Services), the Maryland Society of Hospital Pharmacists (chairman, Board of Directors), the American Association of Colleges of Pharmacy, the American Association for the Advancement of Science (fellow), Rho Chi, Sigma Xi, and other organizations. He has published about 70 scientific and technical articles. Dr. Lamy, his wife Angela, and 3 children reside in Catonsville, Maryland.



Left to right: Mr. Thomas E. Patrick, Dr. Peter P. Lamy, Dr. H. Patrick Fletcher.

The Pharmacy program will be divided into two divisions under Dr. Lamy's direction.

Thomas E. Patrick will head the division of pharmaceutical services and will have responsibility for the operation of all the distributive functions. He will also coordinate the participation of students of the pharmacy school in the service functions of the hospital pharmacy.

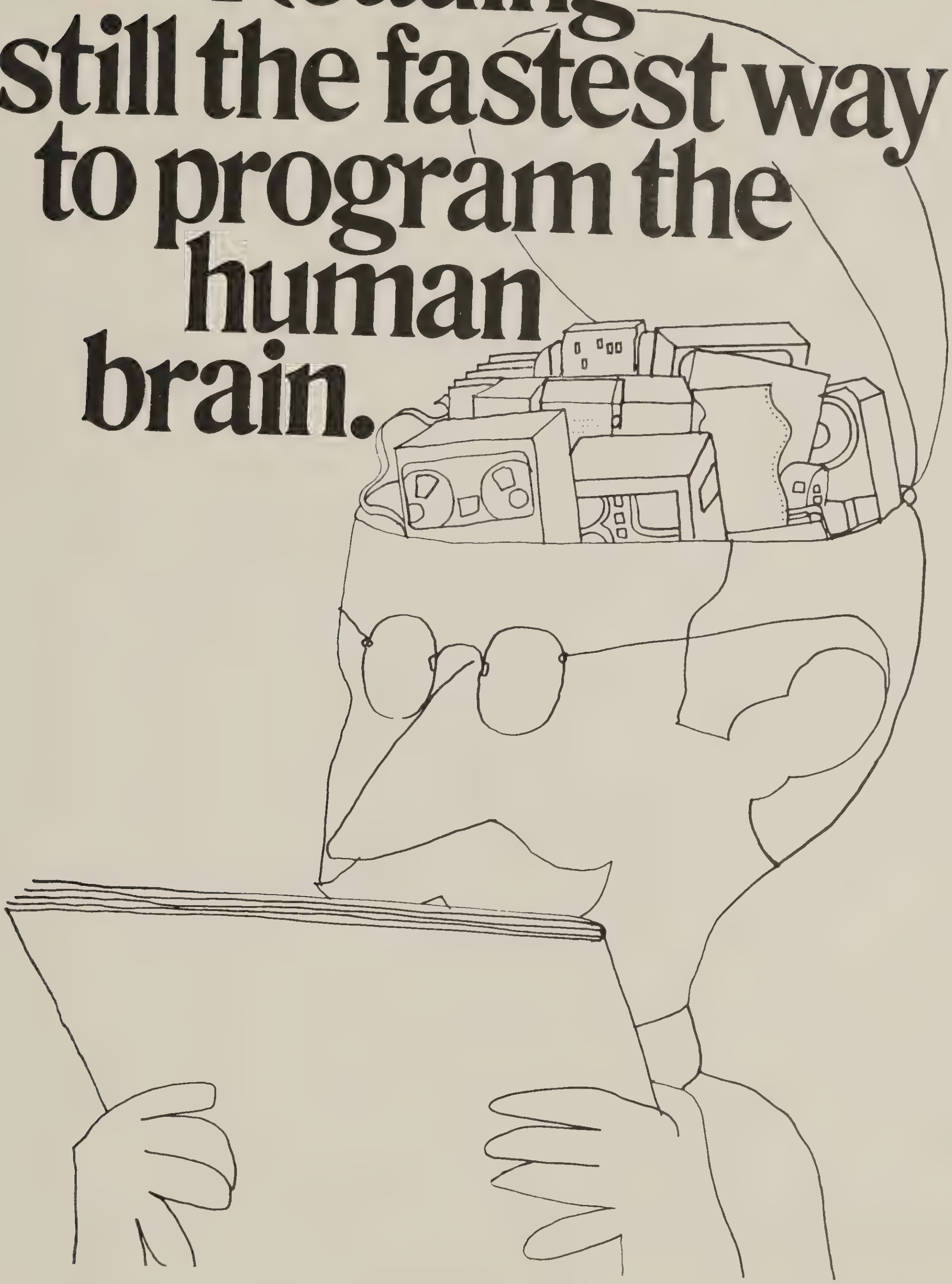
Mr. Patrick received the B.S. in pharmacy from the University of Maryland. After service in the U.S. Navy, attached to the Fleet Marine Force, he pursued a career in community and industrial pharmacy. In 1967, he was appointed senior pharmacist at University Hospital and in 1969, acting director of pharmaceutical services.

Mr. Patrick, who holds a faculty position in the School of Pharmacy, is a member of the American Pharmaceutical Association, the American Society of Hospital Pharmacists, and the Maryland Society of Hospital Pharmacists, of which he was recently elected treasurer. Mr. Patrick resides with his wife Jean and two children in Linthicum, Maryland.

Dr. H. Patrick Fletcher will assume direction of the division of clinical pharmacy in the School of Pharmacy and the hospital. Dr. Fletcher, after completing service in the U.S. Navy hospital corps, received the B.S. (Pharmacy) from Purdue University, and the M.S. and Ph.D. in Pharmacology also from Purdue. He then joined the Upjohn Company as a research associate and worked in the area of intestinal absorption and drug availability.

In 1969, Dr. Fletcher joined the faculty at the School of Pharmacy as an assistant professor in pharmacy and pharmacology, and was given the responsibility of developing a clinical pharmacy teaching program at University Hospital for pharmacy students. He is a member of the American Pharmaceutical Association, the Academy of Pharmaceutical Sciences, the American Association of Colleges of Pharmacy, the American Association for the Advancement of Science, and Sigma Xi. Dr. Fletcher resides with his wife Janet and three daughters in Baltimore.

Reading is still the fastest way to program the human brain.



In an era of "information explosion," how do you "program" information to the human brain? Spoken language is far too slow. The average person speaks about 150 words per minute. Fast readers can read up to 1,500 words a minute—ten times the average rate for the spoken word. Perhaps this is why millions of people regularly purchase from pharmacies, magazines, paperbacks, comics and newspapers from insight and enjoyment.

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Maryland Society of Hospital Pharmacists

Fifth Annual Seminar

PHOTOS (l. to r.)—**Upper left**—Sydney L. Burgee, Jr. receives 1st Annual W. Arthur Purdum Award from President Samuel Lichter. **Upper right**—Speakers and Seminar Committee: Robert E. Snyder, Steven Cohen, Dr. Ruth Milette, Dr. Peter P. Lamy, Dr. Mary Ellen Kitler, Mary W. Connelly (general chairman), Samuel Lichter, Albert F. Gilbert, Murray Ginsberg, Robert Lantos and Patrick Birmingham. **Lower left**—Officers: Reelected Secretary, Normand A. Pelissier; out-going Treasurer Dudley A. Demarest; incoming President Robert E. Snyder; President-Elect Mary W. Connelly; incoming Treasurer Thomas E. Patrick; out-going President Samuel Lichter. **Lower right**—President Robert E. Snyder presents MSHP Student Achievement Award to David Roffman, Univ. of Md. Class of 1970.

The Fifth Annual Seminar of the Maryland Society of Hospital Pharmacists was held on June 12, 13 and 14, 1970 at the Carousel Motel in Ocean City, Maryland This year, the MSHP celebrated the 25th anniversary of its founding. President Samuel Lichter, in his out-going speech, touched upon past events of importance that have occurred in the Society's 25 year history. He noted that many of the early leaders in the Society are still active.

The program arranged by Dr. Peter P. Lamy, was outstanding. Among the speakers were Robert Lantos, nominee for the Presidency of the American Society of Hospital Pharmacists. Mr. Lantos is Director of Pharmacy at the Shands Teaching Hospital and Clinics, Gainesville, Florida. His topic was entitled "The Pharmacist's Role in the Detection and Reporting of Adverse Drug Reactions." Robert C. Bogash, President of Paramed, Inc., Englewood, New Jersey, spoke on "What's New in Packaging—What Will Be New Tomorrow?" Dr. Mary Ellen Kitler, Office of the Medical Director, Ciba Ltd., Basle, Switzerland presented "Satistics in Clinical Pharmacy."

Other speakers and their topics were: Dr. Ruth Milett of the School of Pharmacy, "The Behavioral Sciences an Patient Care" and Steven Cohen, Murray Ginsberg an Patrick Birmingham, pharmacists at the Good Samarita Hospital in Baltimore, "The Pharmacist in Patient Care— Report of An Actual Program." Mr. Birmingham is Dire tor of Pharmacy Service at the hospital. Donald F. Best Director of Pharmacy Services at the Yale-New Haven Ho pital addressed the seminar on "What's New in Drug Di tribution—What Will be New Tomorrow?" and Albert Gilbert, Assistant Administrator at Mercy Hospital in Ba imore spoke on "How To Convince Your Adminisrator Saturday evening's banquet featured Mrs. Jean T. Ma Vicar, Director of Nursing at University Hospital, Balt more, as banquet speaker. Her talk was entitled "Nursir and Pharmacy—Towards Better Patient Care."

Among the award winners at the installation banqu were Samuel Lichter, who received the Geigy Achieveme

(*Continued on page* 18)

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(*Continued from page* 16)

Award, Sydney L. Burgee, Jr., who received the First Annual W. Arthur Purdum Award for his contributions to Hospital Pharmacy and Paul LeSage, who received a special going-away award commemorating his service on behalf of the MSHP. In addition, David Roffman, University of Maryland Class of 1970, was presented the MSHP Student Achievement Award at the Sunday morning session.

The new officers for 1970-71 who were installed at the Saturday Banquet are: President, Robert E. Snyder; President-Elect, Mary W. Connelly; Secretary, Normand A. Pelissier; and Treasurer, Thomas E. Patrick. General Chairman for the three-day Seminar was Mary W. Connelly, Chief Pharmacist at Mercy Hospital in Baltimore.

The Society is again indebted to the drug manufacturers for their financial support of the Seminar. The entertainment this year was provided by the "Counterpoints" who returned to this year's Seminar by popular demand of those attending last year. The fashion show at Saturday's luncheon, put on by Hess Apparel was delightful. The models featured a wide range of outfits from cocktail party wear to beach wear which the men found interesting.

Recent promotions and personnel changes

Effective July 1, 1970, Sydney L. Burgee was promoted from Chief Pharmacist to Director of Pharmacy and Central Supply Services at the Union Memorial Hospital, Baltimore.

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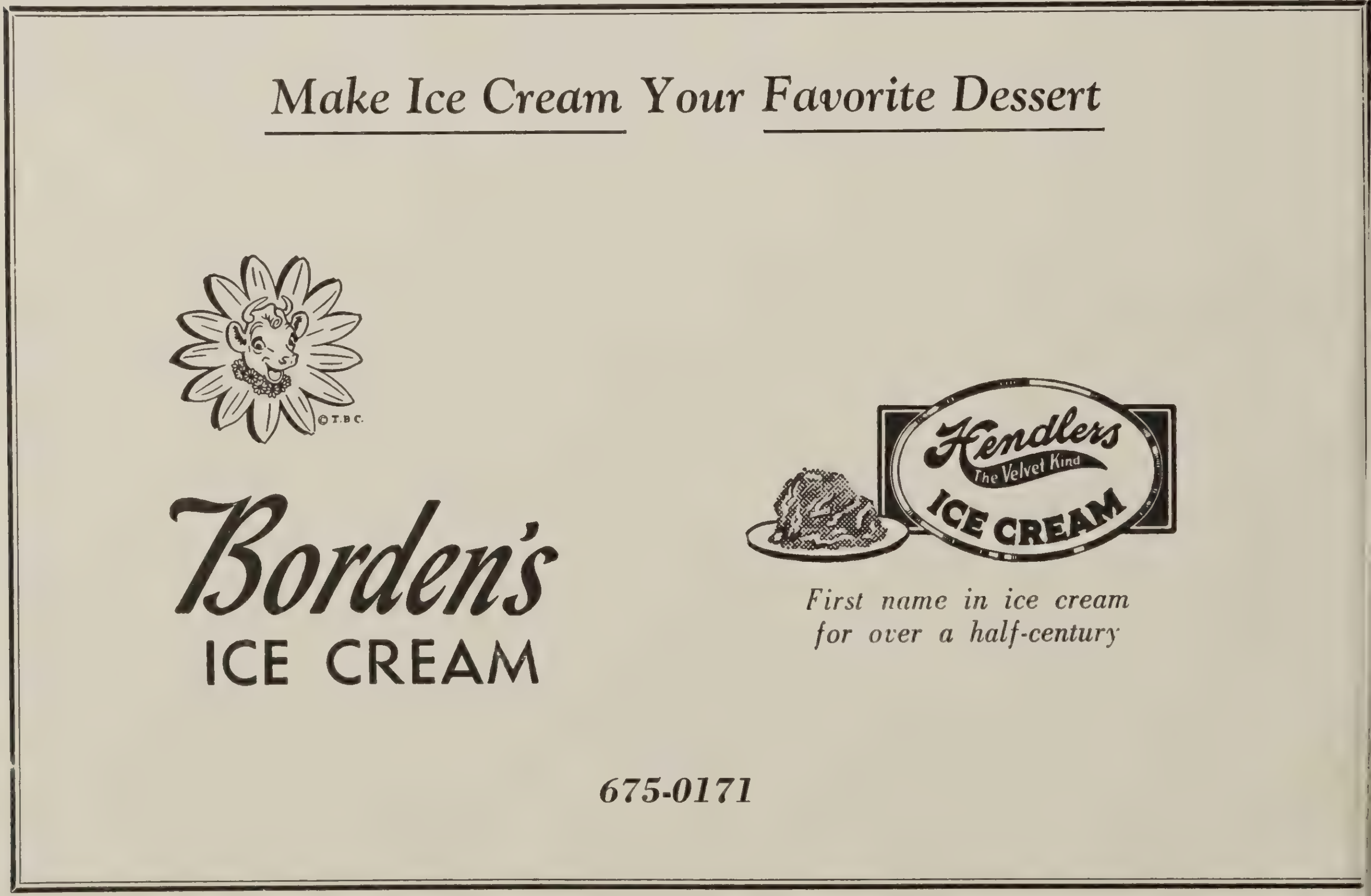

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Syrup of Ipecac in Acute Poisoning

by

Ralph F. Shangraw, Ph.D.
Professor and Chairman
Department of Pharmacy
University of Maryland School of Pharmacy

An extremely disturbing and potentially dangerous inident occurred in a Baltimore inner city pharmacy this ionth. A mother, whose child had ingested d-Con (Wararin) rat poison; was directed by the Poison Center at ie University of Maryland School of Pharmacy to obtain fl. oz. of Syrup of Ipecac from a nearby pharmacy and dminister it to the child. The pharmacy refused to sell the yrup of Ipecac to the mother not once but twice: first on ie basis that she tried to use her medical care card and a econd time, when she had the money, on the basis that yrup of Ipecac could be sold only on prescription. The isensitivity and ignorance of the pharmacist could very ell have cost the life of the child. Fortunately, the child omited as a result of the ingested poison and no serious onsequences resulted.

Upon contacting the pharmacist, it was determined iat the Syrup of Ipecac in his possession did bear a *preription only* label and that he was not aware of the Food id Drug Administration directive allowing the sale of fl. oz. quantities of Syrup of Ipecac for emergency treatent of poisoning. Excertps from this directive are reproiced below. (Published in the Federal Register of Octoer 27, 1965)

> . . . the Commissioner of Food and Drugs has determined that it is in the interest of the public health for ipecac syrup to be available for sale without prescription, provided that it is packaged in a quantity of 1 fluid ounce (30 milliliters), and its label bears, in addition to other required label information, the following, in a prominent and conspicuous manner:
>
> (1) A statement conspicuously boxed and in red letters, to the effect: "For emergency use to cause vomiting in poisoning. Before using, call physician, the Poison Control Center, or hospital emergency room immediately for advice."
>
> (2) A warning to the effect: "Warning—Keep out of reach of children. Do not use in unconscious persons. Ordinarily, this drug should not be used if strychnine, corrosives such as alkalies (lye) and strong acids, or petroleum distillates such as kerosine, gasoline, coal oil, fuel oil, paint thinner, or cleaning fluid have been ingested."
>
> (3) Usual dosage: 1 tablespoon (15 milliliters) in persons over 1 year of age.

Syrup of Ipecac has been found to be an emetic of oice for self-administration due to the completeness of emesis obtained. All pharmacies should carry properly eled 1 fl. oz. bottles of Syrup of Ipecac and the distrition of these to families with children is an excellent y of achieving good will for the pharmacy and the prosion.

The dose of Syrup of Ipecac for a child one year or older is *one tablespoonful* which may be repeated in 15 minutes, if vomiting has not occurred. The drug must be followed immediately by at least 8 oz. (one full cup) of water. Ipecac is not a contact emetic and therefore a delay of action up to 15 minutes can be expected. The alkaloids, emetine and cephaeline function by acting mainly on the vagus center in the medulla.

Two cautionary notes:

(1) Last December a number of lots of Ipecac Syrup U.S.P., manufactured by Eli Lilly and Company were recalled from the market due to the fact that the alkaloid ratio in some lots was not correct for producing effective emesis. (The lot numbers are 2 NT 40B, 3B SO8 B, 3B SO 8 A, 3 EV 62 A, 3F S78 A, and 3 HL, 67A). Any syrup from these lots should be returned to the company. The problem apparently arose from contamination of the crude drug and not due to errors in manufacture. Syrup of Ipecac distributed by two manufacturers other than Lilly was not found to be contaminated.

(2) Caution should always be taken to assure that *Fluidextract* of Ipecac is *never* dispensed when the syrup is called for. *Use of the fluidextrast in place of the syrup in children could be fatal.*

In summary, Syrup of Ipecac in properly labeled 1 fl. oz. containers should be available without a prescription in all community pharmacies for distribution in the case of emergency poisoning. *YOU MAY HELP TO SAVE A CHILD'S LIFE.*

FOR INFORMATION OF ANY TYPE CONCERNING POISONING, CALL THE POISON INFORMATION CENTER AT THE UNIVERSITY OF MARYLAND SCHOOL OF PHARMACY — 955-7592, *OR AT NIGHT OR WEEKENDS* — 342-0800.

Obituaries

The following deaths not previously reported are listed as a matter of record:

Robert N. Abramowitz, 63, died August 30, 1969.
Robert Harold Chatkin, 67, died June 9, 1969.
Sister Agnes Fitzsimmons, 83, died December 7, 1969.
Thomas Gorban, 59, died April 5, 1970.
Harold M. Goldfeder, 51, died September 27, 1969.
Albert G. Hahn, 72, died November 26, 1969.
Jerome Honokofsky, 55, died October 28, 1969.
Samuel London, 62, died October 26, 1969.
Jacob Sholom Meyers, died September 24, 1969.
Nathan G. Pelovitz, 60, died October 21, 1969.
Joseph I. Smith, 62, died November 25, 1969.

Meprobamate Controlled

Some Combinations Exempt

On July 6, 1970, Meprobamate became a controlled drug under DACA; however, certain combination Meprobamate products have been exempted from control per announcement in the Federal Register on July 4, 1970. To aid you in responding to inquiries the following combinations are exempted in the Federal Register:

Milprem	200 (Wallace)
Milprem	400 (Wallace)
Milpath	200 (Wallace)
Milpath	400 (Wallace)
Miltrate	10 (Wallace)
Miltrate	20 (Wallace)

In addition, any other products with an exactly alike formulation with the same or a lesser amount of Meprobamate are also exempted. The additional combinations which have been identified as exempt under this criteria are as follows:

PMB	200 (Ayerst)
PMB	400 (Ayerst)
Pathibamate	200 (Lederle)
Pathibamate	400 (Lederle)
Equanitrate	10 (Wyeth)
Equanitrate	20 (Wyeth)

U.S.P. XVIII

The new U.S.P. XVIII is now off the press. This year marks the 150th anniversary of the founding of the United States Pharmacopoeia, which is the legal standard in the United States for selected drugs and pharmaceuticals. The organization which compiles and publishes the Pharmacopoeia has served continuously since 1820, and is made up of delegates from academic institutions and professional associations of both medicine and pharmacy, as well as some departments of the federal government.

In January, 1817, Dr. Lyman Spalding, of New York City, submitted to the Medical Society of the County of New York a program for the formation of a National Pharmacopoeia. Dr. Spalding's plan was to divide the United States into four districts—Northern, Middle, Southern and Western. The plan provided that a convention should be called in each of these districts, to be composed of delegates from all of the medical societies and schools situated within each of them. Each district's convention to be held in Washington, D.C. From the materials brought together by the four district pharmacopoeias, a National Pharmacopoeia should be established. During 1818 and 1819, two of the four district groups met and finally eleven delegates assembled in the Capitol, January 1, 1820, to draft the first National Pharmacopoeia.

The eighteenth revision published this year recognizes more drugs and dosage forms than have been listed before in any modern pharmacopoeia. It is available at $17.50 per copy from Mack Publishing Co., 20th and Northampton Streets, Easton, Pennsylvania 18042.

Blue Cross Appoints Pharmacy Advisory Committee

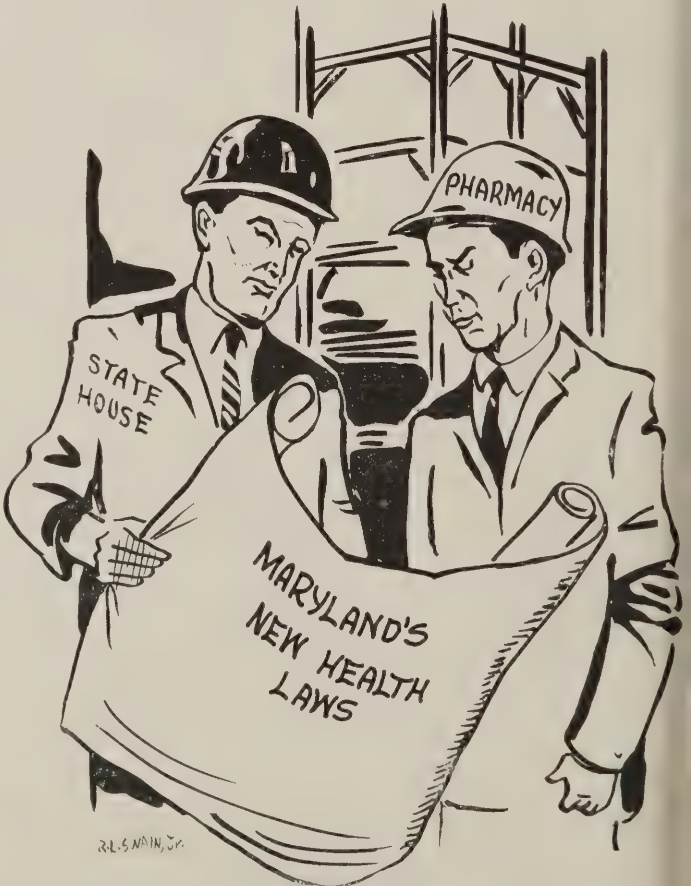
Donald O. Fedder, of Baltimore; I. Earl Kerpelman of Salisbury; Bernard B. Lochman, of Baltimore; John R McHugh, director of professional services, Peoples Servic Drug Stores, Inc.; and Samuel Wertheimer, of Cumberland, have been appointed as members of the Marylan Blue Cross Pharmacy Advisory Committee. The purpos of this Committee is to give guidance and make recommendations to officers of Maryland Blue Cross on professional and procedural matters affecting the Blue Cros Prescription Program.

Blue Cross will consult with the Committee for advic and counsel on varying aspects of the program, includin such matters as generic drugs, chronic and maintenanc medications, review of situations involving complicate termination for cause, assistance in settling disputes wit pharmacists, and controls for eliminaion of abuses.

The Pharmacy Advisory Committee met for the firs time on May 21, 1970, and elected Mr. Donald O. Fedde as chairman.

Increase In Professional Fee

In order for pharmacies to meet their increasing cost and expenses, Maryland Blue Cross is increasing the professional fee. Effective October 1, 1970, the professiona fee of $1.85 will be increased to $1.95.



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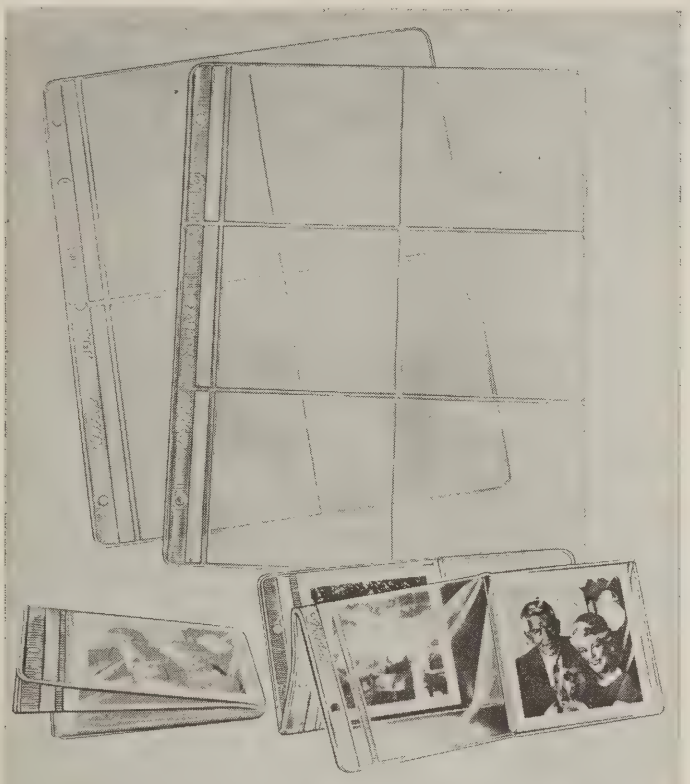

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Alpha Zeto Omega Presents its "AZO Order Of The Double Star to Paul Reznek

The Alpha Zeta Omega Pharmaceutical Fraternity has presented its "AZO Order of the Double Star" to Paul Reznek, Secretary and immediate Past President of the Prince George-Montgomery County Pharmaceutical Association and National AZO Editor.

Mr. Reznek is a former Assistant Editor of the "Maryland Pharmacist" and former Editor of the "Bi-County Pharmacist."

The award was presented recently at a dinner in Washington, D.C. by AZO's National President, Herman S. Langer, of Milwaukee.

In the photo, left to right, are: Irving Rubin, Editor of "Pharmacy Times," AZO National President Herman S. Langer, Paul Resznek and Paul Pumpian, presentation speaker, former Secretary of the Wisconsin State Board of Pharmacy and the FDA.

Chain Store Report

PEOPLES: First-quarter profit overturns '69 loss

In a sharp about face, Peoples Drug showed a net profit of $55,975 for the first quarter of fiscal 1970, against a $139,666 loss for the same three-month period in 1969. Sales for the period were $47,112,187, 5.5% above the $44,660,973 registered for the identical period in 1969.

Behind the earnings upturn is Peoples' ongoing program of phasing out or remodeling older D.C. stores and opening newer, larger units in the suburbs. Also playing a role is the chain's new computer which is helping to cut costs at a time when they were beginning to get out of hand.

DRUG FAIR Boosts Sales by 22.8 percent

Total sales for the 9 month period ended March 31, 1970 of $92,256,198, an increase of 22.8%, was contributed to partly by a 26.4% increase in sales for the third quarter.

During the third quarter, five stores were modernized, and, according to chain president Milton Elsberg, the modernization program will continue. As of March 31, 1970 there were 120 stores in operation compared to 114 in 1969.

Hospitals Issued Medicaid Physician Account Numbers

In an effort to obtain necessary data pertaining to the operation of the Maryland Medical Assistance Program, the below listed hospitals with large out-patient clinics will be assigned specific prescriber numbers to be used on the Prescription and Pharmacist's Invoice (Form MS-6).

Hospital	*Prescriber Number*
Baltimore City	H001
University of Maryland	H002
Church Home	H003
Johns Hopkins	H006
Maryland General	H008
Mercy	H009
Provident	H010
Sinai	H013
South Baltimore General	H014
Union Memorial	H015
Bon Secours	H017
Prince George's General	H034
Greater Baltimore Medical Center	H045

During fiscal year 1969 one out of every three Medical Assistance prescriptions lacked a physician's account number. A large percentage of these prescriptions originated in hospitals where many physicians do not have State Medical Assistance Provider numbers. By assigning numbers, and eventually imprinting them upon the forms, it will now be possible to obtain from the computer not only where prescriptions are filled, but also the origin of each prescription.

U. of M. Pharmacy Student Testifies Before House Subcommittee

Miss Darlene F. McMahon, student at the U. of Md. School of Pharmacy and Chairman of the Student APhA Subcommittee on Legislation testified on June 2 before the Subcommittee on Labor, Health, Education and Welfare of the U.S. House of Representatives.

Miss McMahon stated, "We cannot emphasize strongly enough our sincere belief that this time of crisis in health care delivery is not the time to reduce financial assistance to students of the health sciences."

Her testimony was in response to President Nixon's proposal to reduce the number of loans to Medicine, Dentistry and to other health related groups by about 25 per cent as compared to fiscal year 1970.

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No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

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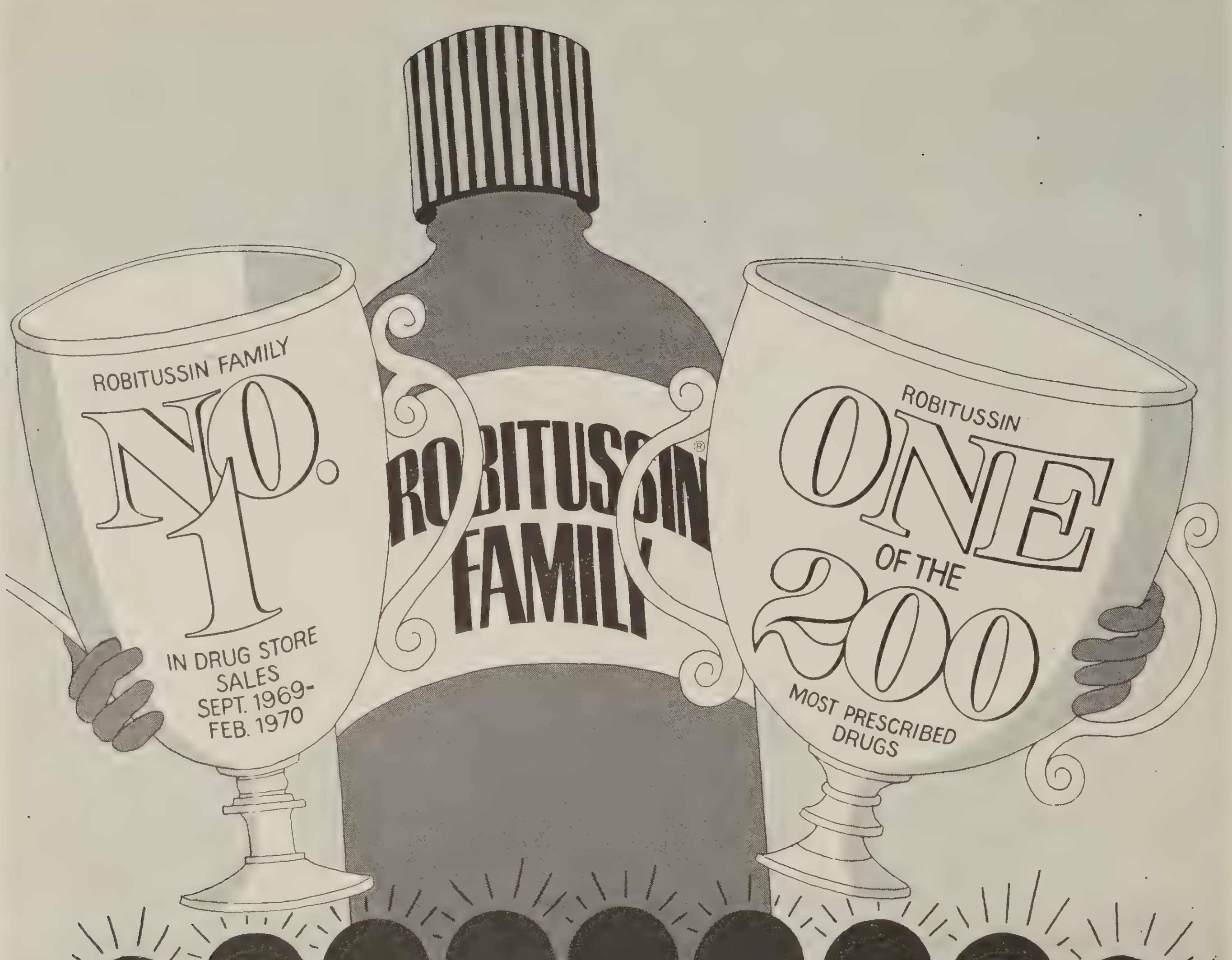
References:
(1) Siver, R. H.: CMD, **21**:109, September 1954. (2) Frykman, H. H.: Minn. Med., **38**:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., **51**:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., **15**:15-16, October 1965. (5) Weekes, D. J.: NY State Jour. Med., **58**:2672-2673, August 1958. (6) Ellis, S. and Spratt, J. S.: JOUR. AMER. GER. SOC., **18**:410-415, May 1970.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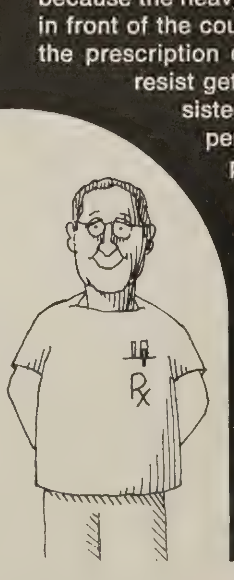
Last September the Robitussin family took over the Number 1 spot in cough preparation sales for the first time in its 20-year history. And it held this lead throughout the 6-month cough and cold season. During the first two months of 1970 sales were up 25% while the market was down 2%. Did you know that during 1969 customers spent $2 million more on the Robitussins than in 1968? This whopping increase was recorded both in chains and independent drug stores.

And now another honor. Robitussin has broken into the top 200 most often prescribed drugs in the industry. You can't go wrong with the Robitussin line because the heavy demand is always there—both in front of the counter and back of the counter in the prescription department. How could anyone resist getting on deal products that consistently put on such an outstanding performance! Stock, promote, display, and sell the leading ethical OTC cough preparation line—the Robitussin family.

A special thanks to you, Mr. Pharmacist, for making this award winning performance possible.



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MARYLAND PHARMACEUTICAL ASSOCIATION
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the maryland pharmacist

DONALD O. FEDDER
President
Maryland Pharmaceutical Association
1970-71

(*see page 6*)

Volume 46 AUGUST 1970 Number 8

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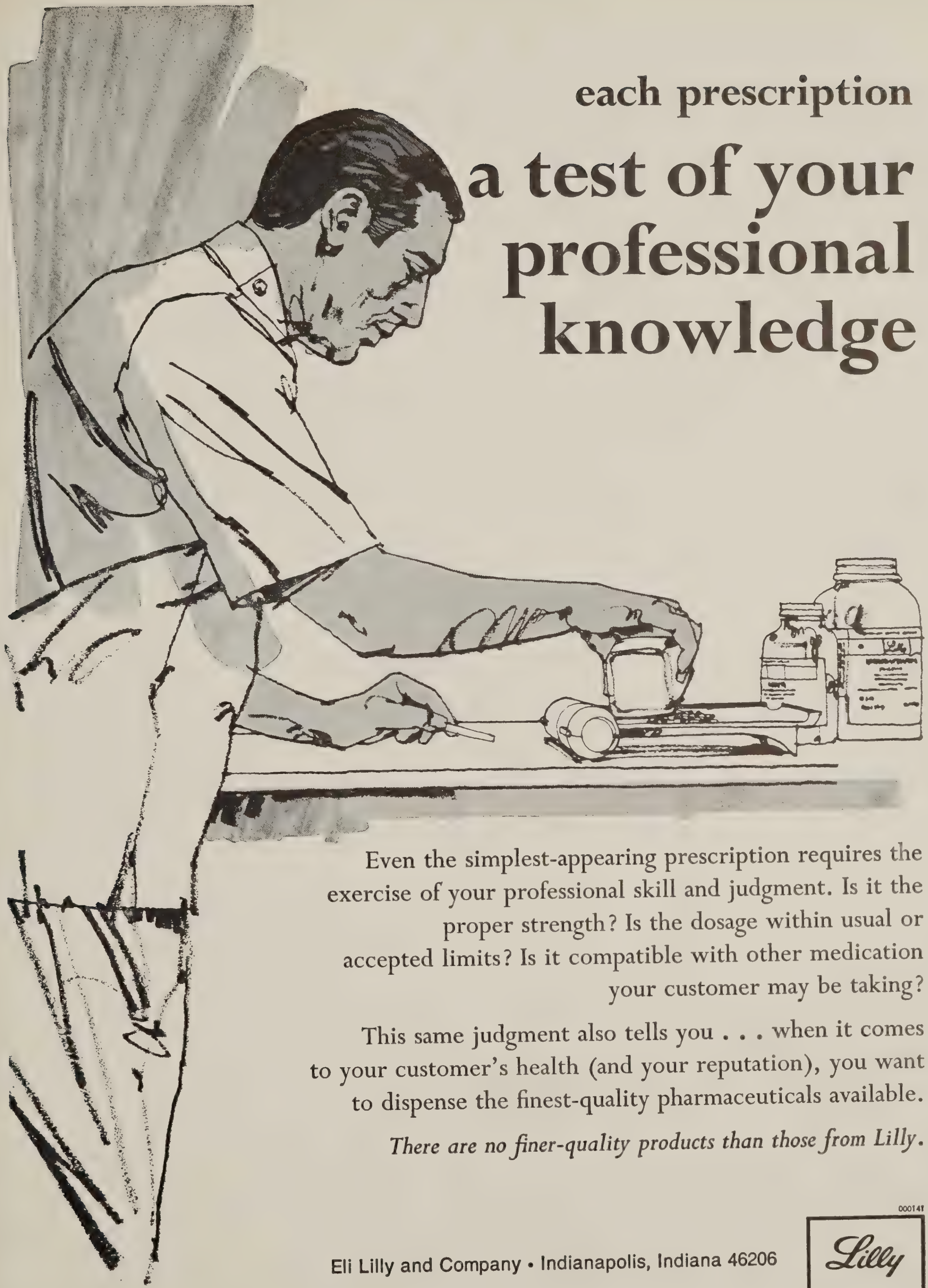

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The Maryland Pharmacist

MEMBER STATE PHARMACEUTICAL EDITORIAL ASSOCIATION SPEA

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650 WEST LOMBARD STREET BALTIMORE, MARYLAND 21201

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Donald O. Fedder Installed President Maryland Pharmaceutical Association

Donald O. Fedder, a native of Baltimore, was elected President of the Maryland Pharmaceutical Association at the 88th Annual Meeting, held at the Shelburne Hotel, Atlantic City, New Jersey, July 12-16. Mr. Fedder graduated from the University of Maryland School of Pharmacy in 1950. He also attended Western Maryland College, and served in the U. S. Army 1945-1946. In 1951 he opened Fedder's Pharmacy in Dundalk and established a convalescent aids department and a fitting service for orthopedic and surgical braces and appliances. He formed the Dundalk Medical Supply Company in 1959 and in 1965 opened a branch office in downtown Baltimore exclusively devoted to fitting braces and supports.

Mr. Fedder has long been active in pharmaceutical associations at the local, state and national levels. He was the MPhA's Finance Committee Chairman in 1967 and 1968 and Chairman of the Health and Welfare Committee from 1967 to 1970. He is active in the American Pharmaceutical Association where he was a member of the Social and Economic Relations Committee in 1968-1969 and Co-Chairman of the Professional Relations Committee from 1969-1971. He served as President of the Baltimore Metropolitan Pharmaceutical Association in 1968.

In addition, he was a member of the Medical Assistance Advisory Committee of the Maryland State Department of Health and the Curriculum Revision Committee of the University of Maryland School of Pharmacy. He serves as a member of the Allied Health Committee, Maryland Regional Medical Program Service Committee, Maryland Division-American Cancer Society and Chairman of Maryland's newly formed Blue Cross Pharmacy Advisory Committee. In 1969 he was elected Director of Calvert Drug Company.

Mr. Fedder has made presentations before a number of pharmacy groups including the NARD, Delaware and Pennsylvania pharmaceutical associations and has published in the *American Professional Pharmacist.*

He holds membership in the Dundalk Luncheon Optimist Club, serving as President 1963-1964. He is a Director of the Dundalk Concert Association and member of the Heart Association of Maryland, Baltimore League for Crippled Children and Adults, Advertising Club of Baltimore, and Baltimore Association for Histadrut.

Mr. Fedder is married to the former Norma Kolodner and has two children, Debra 20, a junior at the University of Maryland, and Ira, 16.

Don Fedder has also been active in the legislative activities of the Maryland Pharmaceutical Association. This fall he is a candidate for the House of Delegates from the Second District of Baltimore County.

Morris L. Cooper Honorary President - Maryland Pharmaceutical Association 1970 - 1971

Morris L. Cooper was elected Honorary President of the Maryland Pharmaceutical Association for 1970-1971. A graduate of Baltimore Polytechnic Institute and University of Maryland School of Pharmacy (1926), he served as President of the Baltimore Metropolitan Pharmaceutical Association in 1948.

He is a member of the Rho Chi Society, the Royal Society of Health in London, and the American Institute of the History of Pharmacy.

He invented the "Cooper Mortar and Pestle," one of these being on permanent exhibition at the Smithsonian Institution, Pharmacy Section. He is an ardent collector of rare apothecary jars, show globes, and antique mortars and pestles, having one of the finest collection in this area. His collection was part of a continuous professional window display project in the Cooper Drug Store, which was located at Park and North Avenues, for twenty-five years. During the annual National Pharmacy Week Competition, the window displays, from 1947 to 1964, received eleven state awards and five national awards.

The Cooper Collection of Ancient "Tools of the Apothecary" has been on loan to the Equitable Trust Company and exhibited at the Enoch Pratt Library at the University of Maryland School of Pharmacy and shown on educational television programs.

Mr. Cooper was a delegate to the First World Congress of Pharmacists in Israel, in August 1964. He presented papers before the Fifth Pan American Congress of Pharmacy and Biochemistry in Santiago, Chile, and the Sixth Pan American Congress of Pharmacy and Biochemistry in Mexico City in 1960 and 1963 respectively.

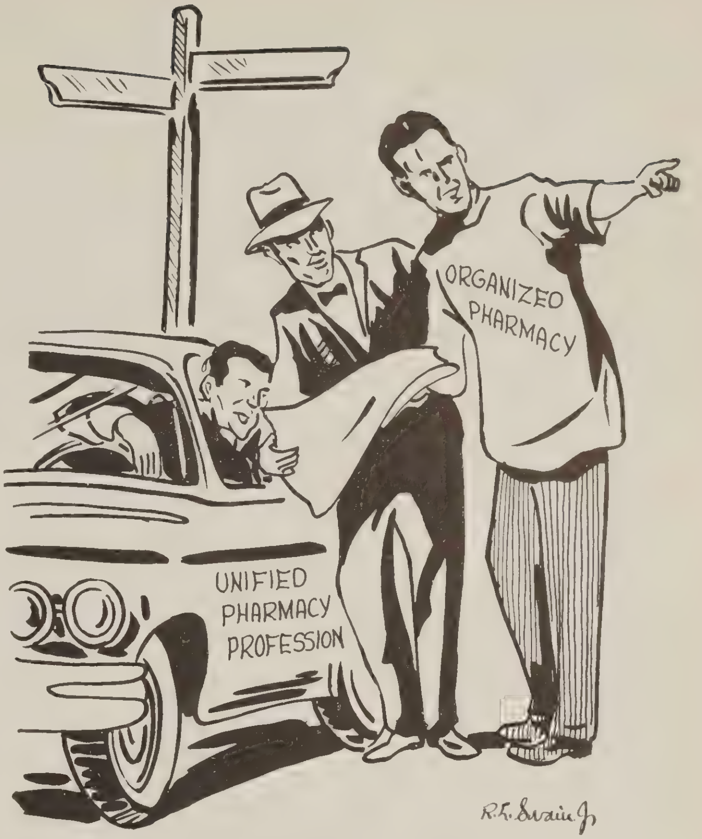
Mr. and Mrs. Cooper joined the University of Maryland Alumni tours of the Orient in 1966 and during the trip visited apothecaries in Japan, Taiwan, Singapore, Manila and Hong Kong.

Pharmacist Cooper presented professional papers at the annual conventions of the American Pharmaceutical Association in Boston, Buffalo, Philadelphia, New York, Jacksonville, Washington, Detroit, Las Vegas and Montreal.

He is presently Curator of the Dr. B. Olive Cole Museum of the Maryland Pharmaceutical Association, where is installed the pharmaceutical antiques on display to the public, in the Kelly Memorial Building, 650 West Lombard Street. He has devoted many hours in this labor of love.

Mr. and Mrs. Cooper have two children, Mrs. Serwin Ritter, a graduate of Wellesley College, whose husband is an Orthopedic Surgeon in Massachusetts, and Miss Pamela J. Cooper, a graduate of Chamberlain Junior College of Boston. Mrs. Cooper is past president of the Ladies Auxiliary of the Maryland Pharmaceutical Association.

Morris L. Cooper is a member of Chizuk Amuno Congregation, Arcana Lodge No. 110 A.F. and A.M. and Scottish Rite Chesapeake Consistory.



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Maryland Board of Pharmacy News . . .

The Maryland Board of Pharmacy met at the office of the Secretary, 2305 North Charles Street, Baltimore, on Wednesday, August 19, 1970 to canvass the grades made in the examinations conducted by the Board on June 22, 23, and 24, 1970. Registration was granted to:

Robert N. Brooks
Edgar L. Davis
Richard Dickinson
George S. Horsburgh
Charles A. P. Johnson, III
John G. Kausch

Having previously passed the theorectical examination, and by virtue of having passed the practical examination, at this time, registration was granted to:

Lindsay A. Barton
Jesse H. Tyson, Sr.

The following passed the theoretical examination, but registration is withheld until they have met the legal requirements for practical pharmacy experience and have passed an examination in practical pharmacy:

Dennis M. Ackerman
Richard M. Adler
Steven Agapis
Arnold R. Alperstein
Charles F. Bates
John P. Becker
Larry A. Bierley
Benjamin M. Bodner
Pamela F. Brown
M. Gary Buddie
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Richard S. Nakles
Russell D. O'Connor
Evie G. Pakkas
Carol M. Paulick
Donald J. M. Phillips
George J. Pletka, Jr.
Janet M. Quinn
Arthur N. Riley
Carol D. Ritchie
David S. Roffman
Ivan I. Rotkovitz
Maurice A. Rumbarger
Gary R. Smith
Alan R. Stoff
George W. Swope
Karen L. Thacker
John Tiano, Jr.
John H. Verhulst
Eric W. Von Bergen, Jr.
Dana S. Weinstock
Bernard Weisman
Frederic M. Weiss
Paul C. Welk, III
Robert L. West
Emil J. Wiatrak, Jr.
Joan P. Williams
Kaye J. Wolf
William J. Zimmerman

Pharmacy Changes . . .

Pharmacy Changes for the month of August:

New Pharmacies

Dart Drug Corporation, Riverdale, Herbert H. Haft, President, 6250 Kenilworth Avenue, Riverdale, Maryland.

MEMCO Prescription Pharmacy, William H. Dyer, Jr., President, 5057 Allentown Road, Suitland, Maryland 20023.

Drug Fair No. 107, Milton L. Elsberg, President, 738 Route No. 50, Cambridge, Maryland 21613.

No Longer Operating As Pharmacies

Standard Drug Company, Ralph Rosenthal, President, 1500 University Boulevard, Hyattsville, Maryland.

Whittlesby Drug Store, P. R. Bergeron, President, 7135 Wisconsin Avenue, Bethesda, Maryland 20014.

Read's, Inc., Arthur K. Solomon, President, 3518 Eastern Avenue, Baltimore, Maryland 21224.

Ambassador Pharmacy, Irvin Albert, President, 3811 Canterbury Road, Baltimore, Maryland 21218.

Read's, Inc., Arthur K. Solomon, President, 719 Washington Boulevard, Baltimore, Maryland 21230.

W. H. Clarke and Company, Minor J. Kavanaugh, 147 Market Street, Pocomoke City, Maryland 21851

Changes In Ownership, Address, Etc.

Purdum Pharmacy, Norton J. Grossblatt, Peter Hirsch, 6901 York Road, Baltimore, Maryland 21212.

Zentz Pharmacy, Inc., Roger C. Lipitz, President, 5460 Park Heights Avenue, Baltimore, Maryland 21215

Edwards and Anthony Drug Company, Inc., Stanley Protokowicz, President, 6510 O'Donnell Street, Baltimore, Maryland 21224.

Dell's Pharmacy, Inc., Robert M. Plummer, President, 15 West Bel Air Avenue, Aberdeen, Maryland 21001.

A. Z. O. Presents Awards

Henry Seidman and Paul Freiman were presented with the *Alpha Zeta Omega Order of the Double Star* for service to Pharmacy and the AZO Fraternity. The awards were presented by Supreme Directorum Herman Langer at the Joint Installation and Awards Banquet of Kappa Chapter of AZO Fraternity on June 14, 1970 at the Statler Hilton Hotel in Baltimore. Also honored at the banquet was Paul Siegel who received a 25 year pin. The Directorum for Kappa Chapter 1970-1971 is Jerry Freedenberg.

ROBITUSSIN® FAMILY
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Last September the Robitussin family took over the Number 1 spot in cough preparation sales for the first time in its 20-year history. And it held this lead throughout the 6-month cough and cold season. During the first two months of 1970 sales were up 25% while the market was down 2%. Did you know that during 1969 customers spent $2 million more on the Robitussins than in 1968? This whopping increase was recorded both in chains and independent drug stores.

And now another honor. Robitussin has broken into the top 200 most often prescribed drugs in the industry. You can't go wrong with the Robitussin line because the heavy demand is always there—both in front of the counter and back of the counter in the prescription department. How could anyone resist getting on deal products that consistently put on such an outstanding performance! Stock, promote, display, and sell the leading ethical OTC cough preparation line—the Robitussin family.

A special thanks to you, Mr. Pharmacist, for making this award winning performance possible.

A·H·ROBINS

A. H. Robins Company Richmond, Va.

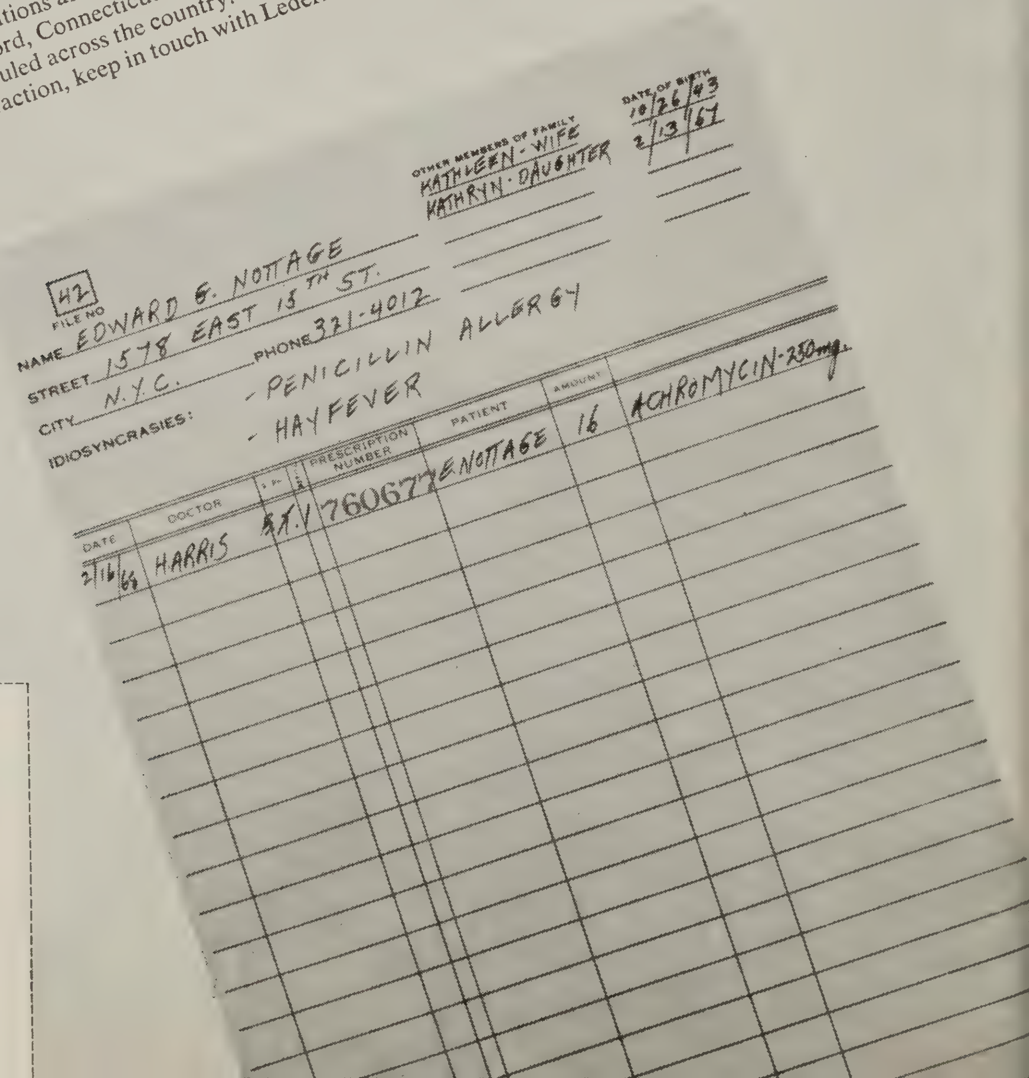
Robitussin® & Robitussin-DM® on deal July 1-Aug. 31. Stock up and save while the price is right.

DRUG INTERACTION:
only you can know who is taking what with what!

As a pharmacist, you are the one most qualified to explain the intricacies of drug interaction not only to your customers—but to all your professional associates in the health care field. You alone have the background for this task.

But even a pharmacist may be at a loss to help his customers unless he has readily at hand the necessary information about which patients are taking which drugs. That's the reason why Lederle will mail to you at your request a sample of a commercially available Family Record Form typical of many in use today. (Simply use the coupon below.) Only with records like these is a pharmacist prepared to advise in individual problems of drug interaction.

Because Lederle is vitally interested in broadening knowledge about this important subject, we have inaugurated a program of Drug Interaction Symposia in collaboration with Schools of Pharmacy, Pharmaceutical Associations and Medical Societies. Two symposia have been held—in Hartford, Connecticut and Binghamton, New York—and others are being scheduled across the country. To keep in touch with developments in Drug Interaction, keep in touch with Lederle.



FILE NO 42

NAME EDWARD G. NOTTAGE

STREET 1578 EAST 15TH ST.

CITY N.Y.C. PHONE 371-4012

IDIOSYNCRASIES: - PENICILLIN ALLERGY - HAYFEVER

OTHER MEMBERS OF FAMILY	DATE OF BIRTH
KATHLEEN - WIFE	10/26/43
KATHRYN - DAUGHTER	2/13/67

DATE	DOCTOR			PRESCRIPTION NUMBER	PATIENT	AMOUNT	
2/16/64	HARRIS	S.T.	1	760677	E NOTTAGE	16	ACHROMYCIN-250mg.

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NAME________________________

ADDRESS______________________

CITY________ STATE______ ZIP_____

Professional Organizations In Pharmacy

Nathan I. Gruz

Executive Secretary, Maryland Pharmaceutical Association
and Baltimore Metropolitan Pharmaceutical Association

Delivered November 4, 1969 to the first professional year students as part of a new course entitled "Introduction to Pharmacy and Health Care."

As pharmacy students you have entered into a new status—you are on the road to becoming health professionals. Even as students, the patients with whom you will be in contact will look upon you as representatives of the profession of pharmacy. With the introduction into the curriculum of clinical pharmacy programs involving both community and hospital pharmacy practice you will probably be in more meaningful patient contact than any previous class of students.

My emphasis—you may have noticed—is on the words "profession" and "professional." A full and clear understanding of the true meaning and significance of these terms is essential to everyone who commits himself to serving the public in a health vocation.

By "profession" we differentiate certain fields of endeavor — certain ways of earning a living — from other fields. "Profession" involves higher education at the college level, the special privileges and obligations granted only after meeting licensure requirements and state examination, commitment to a code of ethical conduct, the exercise of personal judgment and the duty to place the interest and welfare of the public—the people or patients—before personal interest or selfish gain.

There is one more hallmark or distinction of a "professional" person. The members of a profession join together voluntarily to form organizations to develop and set standards of practice and codes of ethical conduct. They freely and willingly create their own societies to establish the machinery for self-regulation of the profession. These societies assume responsibility for providing for educational institutions for the education of practitioners and for facilities for research in their discipline. They seek to assure that these institutions will be alert to meet the changing needs of emerging socio-economic patterns.

Professional organizations exercise the leadership and initiative in developing new health and pharmacy laws and work vigorously for their enactment.

The Maryland Pharmaceutical Association has demonstrated its concern in the areas I have just mentioned. It has been responsible for legislation necessary for adopting the educational requirements for pharmacy we have in Maryland. It has obtained the enactment of pharmacy laws defining the "practice of pharmacy" and unprofessional conduct, including unprofessional advertising. The law bans advertising prices of prescriptions and effectively prohibits the ownership of pharmacies by physicians and dentists.

The MPhA has joined with the state medical society in drawing up a Code of Cooperation between the professions of medicine and pharmacy. Among other things the Code rejects the position of the American Medical Association in condoning physician dispensing of drugs.

The MPhA together with the Baltimore Metropolitan Pharmaceutical Association has been involved in efforts to provide high quality pharmaceutical services in areas of the city where health needs are not being properly met. In line with this objective we secured approval of a plan for pharmacy services whereby patients of the Provident Comprehensive Neighborhood Health Center could obtain their drugs through neighborhood pharmacies. We have met with agencies and groups in other deprived areas to help develop pharmacy services.

We also have inter-professional programs with the health professions such as medicine and dentistry to resolve mutual problems and for education in areas of joint concern.

Our public relations and information activities involve programs to enhance the image of the pharmacist as a professional person, to inform the public of our role as health professionals and to provide service. A pertinent example is in connection with Diabetes Detection Week. As in previous years, pharmacists through the state and local associations will help man testing centers, distribute informative pamphlets, deliver TV and radio talks, and distribute Dreypak Test Kits to patrons in their pharmacies. Pharmacists purchase these Dreypaks but give them out at no charge.

A most important part of Association work is with governmental agencies on such programs as Medicaid to help develop policies, assist members with problems and recommend methods of improvement. MPhA representatives are consulted by local, state and federal officials. They work with Blue Cross and other prescription pre-payment plans to secure the best possible systems.

Other critical concerns are employer-employee relations and mediation of grievances between consumers and other professions.

MPhA for a long time nurtured the concept of continuing education and was largely responsible for the early programs in Maryland. Thus we established the Swain Pharmacy Seminar and the Solomon Pharmacy Economic Seminar. Today, we are fortunate to see the inauguration of an active program under the School of Pharmacy's auspices.

There are many useful services the MPhA office provides such as the employment register, insurance plans and legal counsel on pharmaceutical matters. Through bulletins and publications we disseminate information vital to every pharmacist. The Cole Pharmacy Museum in the Kelly Memorial Building and the Swain Model Pharmacy in the school were established by MPhA.

Another organization with an important role is the Maryland Society of Hospital Pharmacists. The field of the institutional practice of pharmacy is growing and this society serves as a forum for the special interests of this group. It holds informative meetings and seminars and maintains liaison with the MPhA. Many of its members are active in MPhA and serve in positions of leadership in the profession.

To meet the local needs and problems there are county or regional pharmacy groups throughout the state. These include Allegany-Garrett in Western Maryland, the Baltimore Metropolitan Pharmaceutical Association (BMPA), Eastern Shore, Prince Georges-Montgomery County and Washington County (Hagerstown). These are grass roots organizations and are effective with local government and community groups. They maintain close liaison with MPhA, have representatives on its Executive Committee and the first three groups are formally affiliated with MPhA.

Of special interest to you is the support of scholarships by the MPhA and the Student Drug Abuse Committee by BMPA.

On the national scene, we have the American Pharmaceutical Association or APhA and the National Association of Retail Druggists or NARD. The APhA, founded over 125 years ago, is the national professional pharmaceutical society representing all pharmacists. It is responsible for much of the progress of pharmacy in achieving recognition on a national level as a health profession. It has emphasized that the future of a pharmacy is as a full-time health profession and not in the area of non-health related services and products.

The NARD, 70 years old, is an offshoot of the APhA, and was organized to give attention to the mercantile aspects of pharmacy operations. It is made up of and represents interests of pharmacy proprietors. It has devoted itself to such matters as Fair Trade and the promotion of the "drug store" as a source in the community for "convenience items" in addition to health products.

In conclusion, I wish to emphasize that progress for pharmacy—as in all other fields—can only come from the support of and participation in professional organizations by all members of the profession. Thus organizations can be developed that will have the numerical strength and financial resources to do the job. Numbers in membership and the degree of support mean a great deal to government agencies, legislators, other community groups, labor unions and the general public. When pharmacists stay outside of their societies because of apathy or because of a gripe, they only hurt themselves.

Our professional organizations need improvement. By joining and voicing a concern they can be improved from within.

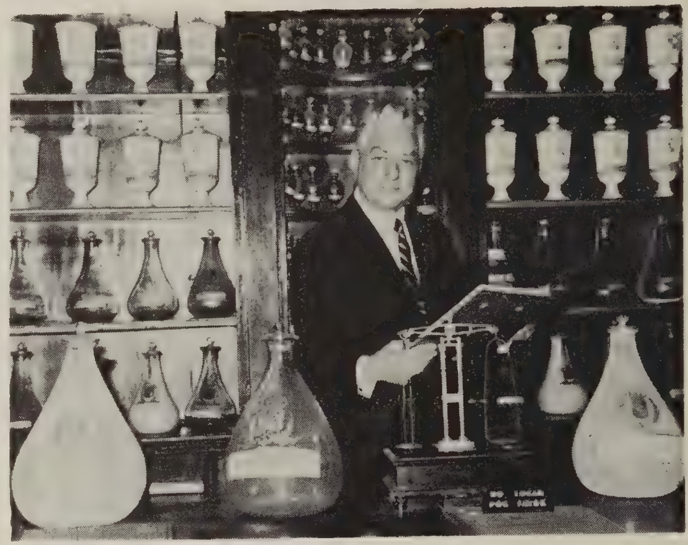
In essence, then, professional organizations mobilize the resources of individual pharmacists into a single, unified body.

Through such a body two vital tasks can be achieved:

1. The enhancement of pharmacy as a profession.
2. The assurance of the highest quality of pharmaceutical services to all people.

Your professional societies — local, state, national, stand ready to help you at all times.

Medieval Family Medication Records Discovered



JAMES E. ALLEN INSPECTING ROYAL FAMILY MEDICATION RECORDS

James E. Allen of Washington, D.C., President and Chairman of the Board of the Henry B. Gilpin Company, drug wholesalers, recently discovered that a comprehensive family medication record system was established as far back as the sixteenth century, in Spain. The family record system was uncovered by Mr. Allen during the recent annual Gilpin Pharmacy Travelcade, which brought more than 330 local pharmacists and their wives to pharmacy seminars in Madrid in April and May.

The medieval record system came to light when the Spanish government granted special permission to Mr. Allen and the group of pharmacists to closely examine and photograph the facilities and records of the Royal Pharmacy Museum in the Royal Palace, Madrid.

The record system was maintained for members of the royal family and preserved since the sixteenth century.

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Geigy
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We did from 1913 into the mid-Twenties. They were rolled on this gold leaf to pick up a fine golden luster.

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Upjohn

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Hospital Pharmacy Section

Hospital of the Month—
Greater Baltimore Medical Center

The Greater Baltimore Medical Center was formed by the merging of two specialized hospitals in downtown Baltimore—The Hospital for the Women of Maryland and the Presbyterian Eye, Ear, Nose and Throat Charity Hospital. The former has ceased to exist, but the Greater Baltimore Medical Center Presbyterian General Out-Patient Clinic (PGOC) still operates in downtown Baltimore. The GBMC opened its doors on Sept. 15, 1965. GBMC is at 6701 N. Charles St., near Towson. It has 400 beds and is a complete general hospital with all services.

HORIZONTAL PLAN—In its construction, the architects took advantage of a 60-acre sloping site to develop a rambling horizontal structure with grade-level access at each of its five floors. Main entrance is at the third level.

UNIQUE DISTRIBUTION SYSTEMS—Two specially designed electric trains, that run on a spiral ramp within the building's core, distribute food, drugs, and supplies from the fifth level to nursing and supply stations on the floors below. Also in operation is an overhead basket conveyor system.

THE PHARMACY—The pharmacy of GBMC, as other supply centers of the hospital, is located on the fifth level of the building. The personnel of the Pharmacy consists of a Chief Pharmacist, Assistant Chief Pharmacist, two staff pharmacists, a technician, a secretary, relief pharmacists and an aide. Pharmacy hours are from 7:30 A.M. to 10:00 P.M. six days a week. In addition to the drugs being delivered by train, another distinctive feature of the pharmacy is the use of the Brewer System. The pharmacy aide prepacks drugs for the Brewer machines. The prepacking consists of over 150 items, including tablets, capsules, liquids, injections, and ophthalmic preparations. The Brewer machines are located at each nursing station in the hospital. The machine, when given the patient's hospital plate, the item identification plate, and the nurse's key, will dispense and charge the drug directly to the patient's bill. All items dispensed by the pharmacy which are not stocked in the Brewer Machines are charged through the IBM 372 Variable Input Station and the 357 Read Station. The pharmacy aide dials in the price of the drug, the patient's hospital number, and inserts an IBM card for the item dispensed. The drug once again is directly charged to the patient's bill.

The GBMC Pharmacy also provides service to Sheppard Pratt Hospital, and provides an on the premises pharmacist for Kernan Hospital and the Presbyterian General Outpatient Clinics.

Federal Wage Garnishment Restrictions

Effective July 1, 1970

On July 1, 1970, the federal Consumer Credit Protection Act (Truth-in-Lending) placed certain restrictions on wage garnishment, the practice by which a creditor legally takes possession of a person's money or property to satisfy a debt.

The federal law places restrictions on the amount of an employee's weekly "disposable earnings" which may be withheld in payment of a debt. "Disposable earnings" are defined to mean the amount remaining after deductions required by law (such as federal and state income taxes, Social Security, etc.) have been withheld.

The restrictions apply to *weekly* earnings in the following manner:

—When disposable earnings for the week are $48 or less, the earnings may not be garnished in any amount.

—When disposable earnings are more than $48, but less than $64, only that amount over $48 is subject to garnishment. Thus, a maximum of $16 may be garnished.

—When disposable earnings exceed $64, 25% of disposable earnings are subject to garnishment.

For pay periods other than a week, the following restrictions apply:

Two-Week Pay Period — Subject to garnishment is 25% of disposable earnings, or the amount by which disposable earnings exceed $96, whichever is less.

Semimonthly Pay Period—Subject to garnishment is 25% of disposable earnings, or the amount by which disposable earnings exceed $104, whichever is less.

Monthly Pay Period—Subject to garnishment is 25% of disposable earnings, or the amount by which the disposable earnings exceed $208, whichever is less.

NOTE: These amounts exempt from garnishment are computed on a multiple (30 times) of the federal minimum wage (now $1.60 an hour). As the federal minimum wage increases, the amount exempt from garnishment will also increase.

OTHER RESTRICTIONS

The federal law also provides that an employer may not discharge an employee on the grounds that the employee's wages have been subjected to garnishment for any one indebtedness. An employer may discharge for garnishment for a second indebtedness, unless state law forbids it.

The Supreme Court in 1969 (Sniadach v. Family Finance Corp.) declared invalid a Wisconsin state law which permitted garnishment of an employee's wages prior to the creditor's obtaining a judgement in the courts. By implication, this decision undercuts similar state laws, then existing in 16 other states. Many of the states have since repealed or modified their laws, so a check of applicable state statutes would be desirable.

RELATION TO STATE LAWS

The federal law does *not* exempt an employer from complying with a state law which places more severe restrictions on garnishments than does the federal statute. States may apply to the Department of Labor's Wage and Hour Division for total exemption from the federal law if they meet certain criteria spelled out in federal regulations.

CHAMPUS—*Civilian Health and Medical Program of the Uniformed Services*

(Information which may affect you as a Pharmacist)

Champus is a program under which beneficiaries may receive a wide range of civilian health care services with a significant share of the cost paid for by the Government. The following categories of persons are eligible for CHAMPUS benefits:

Spouses and children of members serving on active duty under orders which do not specify a period of less than 31 days.

Retired members (and former members) entitled to retired, retainer or equivalent pay and their spouses and children.

Spouses and children of members who die while serving on active duty or while entitled to retired, retainer or equivalent pay.

CHAMPUS is a cost-sharing program. The Government pays a significant portion of the charges determined to be reasonable, and the patient pays the remainder. A charge is allowable under the program if it has been determined to be reasonable. Claims for payment are submitted to civilian agencies under contract with the Government to serve as fiscal agents for the program. In determining if a charge is reasonable, the fiscal agent takes into account the customary charges made by the physician or other specialists for services allied to medicine, and the prevailing charges in the community for similar services.

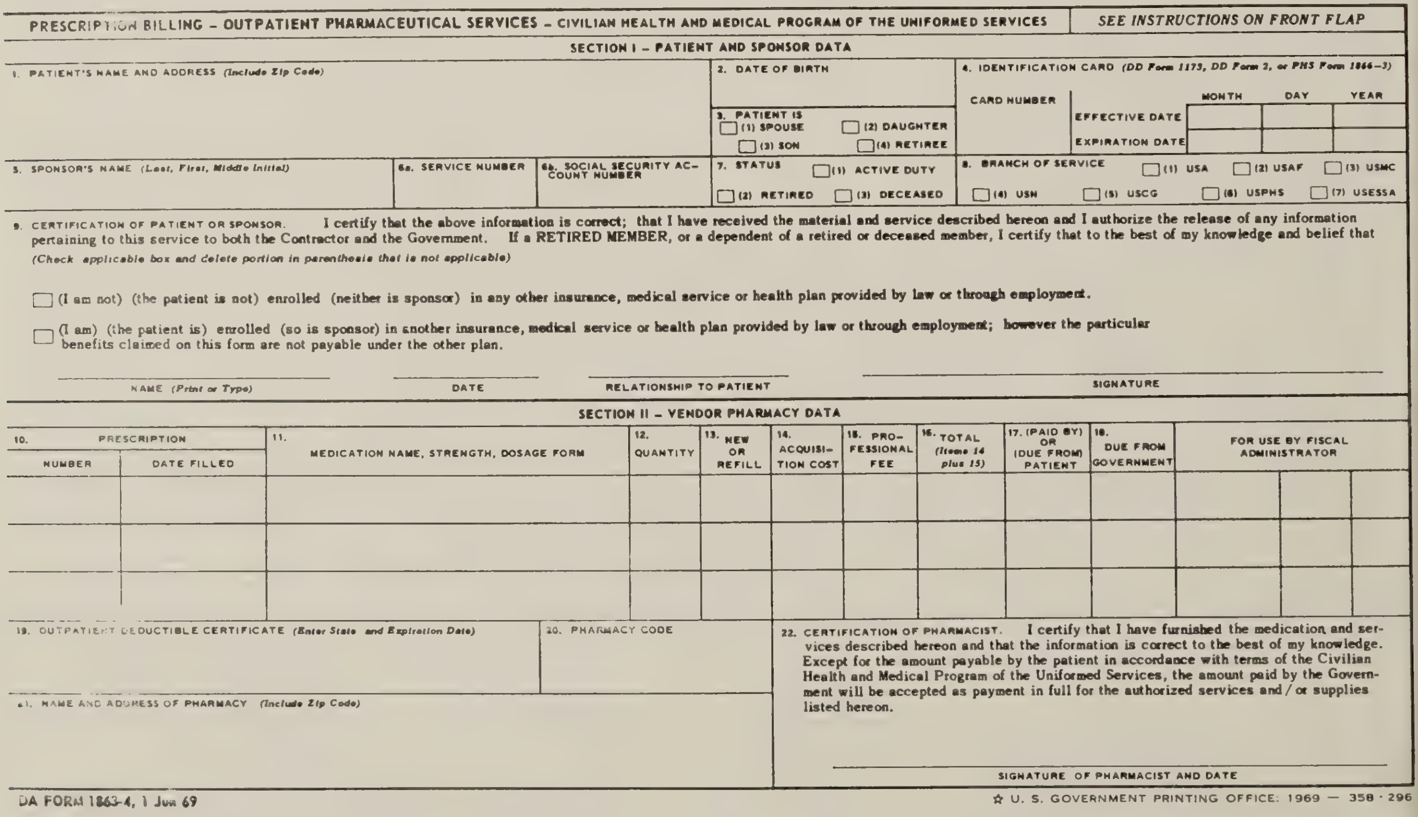
As of April 1, the prescription fee for participating pharmacies in the State of Maryland went from $1.75 to $1.85.

The fiscal agent for Maryland (excluding Prince Georges and Montgomery Counties which are served by the fiscal agent for the District of Columbia) is Maryland Medical Service, Inc., 7800 York Road, Baltimore, Md. 21204.

Outpatient Claims

Deductible Requirement: Beneficiaries are required to pay the first $50 (deductible) of outpatient expenses per patient (not to exceed $100 per family group) each fiscal year (July 1 through June 30) and 20% or 25% (coinsurance) of the allowable charges in excess of the deductible. Dependents of active duty personnel pay 20% coinsurance; all other beneficiaries pay 25%.

Obtaining Deductible Certificate: Beneficiaries accumulate itemized bills or itemized receipts until they equal or exceed $50 for one patient or $100 for the entire family. Each bill or receipt must identify the patient, must indicate the date of the care, and must clearly indicate either the nature of the illness or injury, the procedure performed, or the service provided, and the charges therefor.



PRESCRIPTION BILLING – OUTPATIENT PHARMACEUTICAL SERVICES – CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES | *SEE INSTRUCTIONS ON FRONT FLAP*

SECTION I – PATIENT AND SPONSOR DATA

1. PATIENT'S NAME AND ADDRESS *(Include Zip Code)*

2. DATE OF BIRTH

3. PATIENT IS ☐ (1) SPOUSE ☐ (2) DAUGHTER ☐ (3) SON ☐ (4) RETIREE

4. IDENTIFICATION CARD *(DD Form 1173, DD Form 2, or PHS Form 1866–3)*

CARD NUMBER		MONTH	DAY	YEAR
	EFFECTIVE DATE			
	EXPIRATION DATE			

5. SPONSOR'S NAME *(Last, First, Middle Initial)*

6a. SERVICE NUMBER

6b. SOCIAL SECURITY ACCOUNT NUMBER

7. STATUS ☐ (1) ACTIVE DUTY ☐ (2) RETIRED ☐ (3) DECEASED

8. BRANCH OF SERVICE ☐ (1) USA ☐ (2) USAF ☐ (3) USMC ☐ (4) USN ☐ (5) USCG ☐ (6) USPHS ☐ (7) USESSA

9. CERTIFICATION OF PATIENT OR SPONSOR. I certify that the above information is correct; that I have received the material and service described hereon and I authorize the release of any information pertaining to this service to both the Contractor and the Government. If a RETIRED MEMBER, or a dependent of a retired or deceased member, I certify that to the best of my knowledge and belief that *(Check applicable box and delete portion in parenthesis that is not applicable)*

☐ (I am not) (the patient is not) enrolled (neither is sponsor) in any other insurance, medical service or health plan provided by law or through employment.

☐ (I am) (the patient is) enrolled (so is sponsor) in another insurance, medical service or health plan provided by law or through employment; however the particular benefits claimed on this form are not payable under the other plan.

NAME *(Print or Type)* DATE RELATIONSHIP TO PATIENT SIGNATURE

SECTION II – VENDOR PHARMACY DATA

10. PRESCRIPTION		11. MEDICATION NAME, STRENGTH, DOSAGE FORM	12. QUANTITY	13. NEW OR REFILL	14. ACQUISITION COST	15. PROFESSIONAL FEE	16. TOTAL *(Items 14 plus 15)*	17. (PAID BY) OR (DUE FROM) PATIENT	18. DUE FROM GOVERNMENT	FOR USE BY FISCAL ADMINISTRATOR		
NUMBER	DATE FILLED											

19. OUTPATIENT DEDUCTIBLE CERTIFICATE *(Enter State and Expiration Date)*

20. PHARMACY CODE

21. NAME AND ADDRESS OF PHARMACY *(Include Zip Code)*

22. CERTIFICATION OF PHARMACIST. I certify that I have furnished the medication and services described hereon and that the information is correct to the best of my knowledge. Except for the amount payable by the patient in accordance with terms of the Civilian Health and Medical Program of the Uniformed Services, the amount paid by the Government will be accepted as payment in full for the authorized services and/or supplies listed hereon.

SIGNATURE OF PHARMACIST AND DATE

DA FORM 1863-4, 1 Jun 69

☆ U. S. GOVERNMENT PRINTING OFFICE: 1969 — 358 - 296

For drugs obtainable only by prescription, and for insulin, a drug bill or receipt substantiated by only the following minimum information is acceptable: the name of the pharmacy, the patient's name, the prescription number (for insulin, no prescription number required—bill should specify "insulin"), the date filled and the amount charged. Then beneficiary completes form DA 1863-2 and sends claim form with all supporting documents to the fiscal administrator (address above). The fiscal administrator then issues a certificate indicating that the deductible has been satisfied and reimburses the beneficiary 75% or 80% (as applicable) of the allowable charges which have been paid in excess of the deductible.

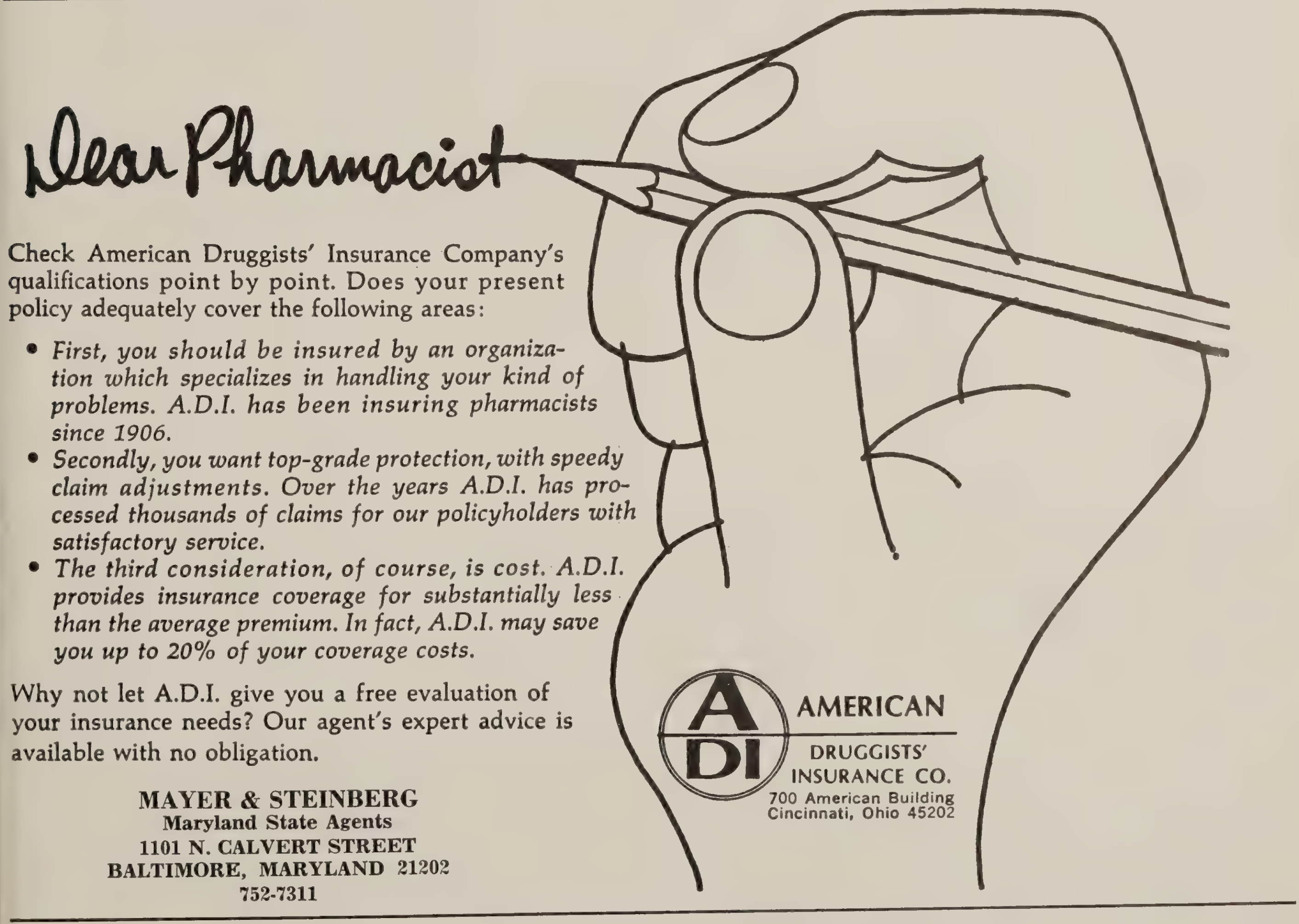
After the deductible has been satisfied and the deductible certificate has been received by the beneficiary, the beneficiary pays the provider only 20% or 25% of his charges, as applicable. The provider applies to the fiscal administrator for payment of the remaining allowable charges. For prescription drugs, (and insulin), the pharmacist must use the Prescription Billing Form DA 1863-4 to seek payment for his services. He may obtain these directly from the fiscal administrator; they are *not* distributed to beneficiaries.

National Drug Code System (NDC)

The National Drug Code System provides an identification system in computer language to permit automated processing of drug data by Government agencies, drug manufacturers and distributors, hospitals and insurance companies.

The system has been developed with Government-industry agreement and consists of a nine-character National Drug Code (NDC). The first three characters are the Drug Labeler Identity Code and are assigned by the Food and Drug Administration. The next four characters are the Drug Product Identity Code which is assigned by the manufacturer or labeler. The 4-character Drug Product Identity Code must be used along with the 3-digit Labeler Identity Code in order to uniquely identify a drug product. The last two characters are the Trade Package Identity Code and these are assigned by the drug firms within parmeters defined by the FDA.

The NDC's may be the codes required for product identification in transactions between hospitals, wholesalers, manufacturers, insurance carriers, individual pharmacies, state welfare departments, SSA, FDA, etc.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. . . THE SYMBOL OF SERVICE TO PHARMACY

The Role of Supportive Personnel In The Pharmacy

by
Henry J. Derewicz
Director of Pharmacy Services
The Johns Hopkins Hospital
Baltimore, Maryland

As part of its continuing program of bringing to its members varying viewpoints on controversial issues in pharmacy, the Maryland Pharmaceutical Association conducted a panel presentation on "The Role of Supportive Personnel in Pharmacy" at the MPhA Spring Regional Meeting, April 17, 1969 at the Chestnut Ridge Country Club in Baltimore County. The following address by Henry J. Derewicz espouses the imperatives and rationale for embarking on the maximum use of non-pharmacists as ancillary personnel in providing pharmaceutical services. Subsequently a different viewpoint entitled "The Role of the Pharmacy Technician in Community Pharmacy," presented by the other panelist, Russell A. Benedict, Executive Secretary, American College of Apothecaries, will be published.

Let me extend my thanks and appreciation for the opportunity to be here not only to share in the festivities of the occasion but also to discuss a subject of great concern to the profession and let me also point out that you should be complimented for having such a discussion on such a controversial subject. This meeting is an example of pharmacists settling their own problems among themselves.

I fully realize that the subject we are discussing is of great concern to all of us. I also realize that it is a subject that stirs the emotions of many pharmacists. I also know that my role here today is not to convince any of you one way or the other. Perhaps all I can do is to offer you the sincerity and objectiveness of my thought process on the subject. I fully realize that much of what I will say many will disagree with and I only ask that the disagreement be on an objective and not emotional basis. So before beginning I think its very vital that I remind each of you of some very obvious facts:

1. Like you, I am a pharmacist.
2. Like you, I am a member of society who seeks out, receives and pays for medical care.
3. Like you, I am vitally interested in our profession, its image, its usefulness, and its contributions.
4. Like you, I have an obligation and a right to speak out on matters which affect the profession and society and its system of medical care.
5. I am a hospital pharmacist who perhaps at times sees another kind of role that the profession must assume for the good of society and for the continual viability of the profession.
6. I come here as an individual only and not as a representative of the Johns Hopkins Medical Institution or any local or national organization. My remarks are my own responsibility.

My remarks this afternoon can be divided into three categories:

I. What are the real questions involved in this business of supportive personnel in the pharmacy?
II. A look at pharmaceutical service in a typical American hospital.
III. What do I think we can do about pharmaceutical service in hospitals and why is the business of supportive personnel an important consideration?

I. The Real Questions

In order to be objective as pharmacists in this discussion of supportive personnel we must be absolutely honest with each other and if we are honest with each other we must forth-rightly and eyeball to eyeball state that you and I have utilized supportive personnel for years in our pharmacies. We have used them to count tablets and pour liquids, type labels and even give the prescriptions to the patient. But, regardless of what we have had them do, we have utilized them. On the other hand, what is it that we are, as pharmacists, really concerned about in this matter of "supportive personnel?"

1. Are we concerned about the economics of the situation and will our competitors use supportive personnel in place of pharmacists and conceivably price their services competitively well below us when we utilize pharmacists?
2. Are we concerned about the quality of pharmaceutical service that is and will be rendered to society?
3. Are we concerned about our jobs? In other words, will supportive personnel replace us?
4. Are we concerned about our profession and its survival and its image?

Defining the Practice of Pharmacy

It seems to me that another big question is how you and I define the practice of pharmacy. When you really think about it, is pharmacy to each of us only the simple mechanical repetitive act of interpreting a prescription, counting or pouring the medication and typing a label? Is this in fact what we are protecting? It seems to me that we must answer another question if we are to be brutally honest with each other. Are we content to admit to each other that "Yes, we use supportive personnel, but let us not formally train them or formally recognize them." Is this because we do not believe regulatory agencies can or will control their utilization or because we do not trust that each of us will utilize supportive personnel ethically and legally?

In short, are we afraid that the profession we belong to cannot or will not regulate and police itself?

Are we concerned that with a possible formal recognition of supportive personnel, the federal government, the state government, or the courts will force the expansion of supportive personnel roles beyond that which our profession has recommended and permitted, such as in the Alabama situation? Frankly, ladies and gentlemen, are not these the real issues in all of the emotional exchange that is going on in regard to supportive personnel? I have not posed these questions because I believe that these are your feelings or concern, but simply because as I review the literature and as I hear others discuss this subject these questions appear to be the essence of the debate. It seems to me that before one, as a pharmacist, can arrive at a logical conclusion or even begin to pose answers or recommendations to this matter that each of us must answer these questions for ourselves. I can assure you that these are the questions I had to answer for myself, for my department, for the hospital and for the patients we serve.

II. Typical Pharmaceutical Service in Hospitals

Now that I have posed the kinds of questions that I believe form the basis of a decision, I should still beg your indulgence as to my conclusions and recommendations by having you visit with me, a typical American hospital. I would like for you to use your imagination and to use me as a television camera within this hospital and to objectively look at what pharmacy as a profession has not done for the society it serves. Let us examine, by means of this human camera, a pharmaceutical service and try to relate what we see to the matter of supportive personnel. You may well ask, "Why look at pharmaceutical service in a hospital?" Well perhaps for two reasons: I am here to talk about the institutional pharmacist's viewpoint on the matter of supportive personnel and (2) because I believe that pharmaceutical service in hospitals is one of the real concerns all pharmacists should have and better have in the future. Let me dwell on this last point for a few moments and to elaborate on this business of why pharmaceutical service in hospitals should be a real concern to all pharmacists.

1. Have you ever stopped to think "where" physicians and nurses receive their first professional exposure to the profession to pharmacy? Do you realize that virtually every physician and every nurse in the United States is educated within a hospital? Do you realize that the impressions formed during this first exposure professionally to our profession can be a lasting one and wouldn't you agree that this first exposure ought to be the best we can possibly give?

2. Depending upon whose survey and data you are using, you are aware that between 30 and 40% of the prescription drugs marketed in the United States are marketed to hospitals and related institutions? That in itself is not of great concern, but what is of concern is that most so called experts agree that by the end of the century percentage will rise to 60 and 70% of the market.

3. Are you aware that hospitals represent one of the top five industries in the United States?

4. Are you aware that possibly 50% of the more than 7,000 hospitals in the United States have no pharmacists at all and that only a few are staffed around the clock?

5. Are you aware that hospital pharmaceutical service represents a medical care contradiction? What I mean by that is that in virtually all areas of the United States an ambulatory patient and one who is not very ill can literally fall into pharmaceutical service with little or no trouble. However, when this very same individual becomes critically ill and in the judgment of his physician must be admitted to an institution, that 50% of American hospitals say they can either not afford or do not need pharmaceutical service provided by a pharmacist. Another aspect of this contradiction is that this patient when admitted is ill around the clock and yet, in the vast majority of this country's hospitals, the pharmacist leaves at 5:00 P.M. and at that magic hour nursing personnel transform themselves magically into pharmacists. Nothing else has changed, the patient is still critically ill.

6. Are you aware that if some legislation were passed today and made effective next Monday, requiring that each hospital in the United States and each extended care facility require pharmaceutical service by a pharmacist, that our profession could not possibly meet the demand for at least 3,000 hospitals plus extended care facilities?

7. Are you aware that patients using hospital emergency rooms and clinics are doing so at an increasing rate each year to the point where here in the State of Maryland 33% of patient visits to doctors in the City of Baltimore were made at the Johns Hopkins Hospital. It is not important at all that these visits were made at the Johns Hopkins Hospital because if we had more hospitals in the City or if a number of hospitals had not left the City, the percentage would be spread out among other hospitals. In fact, are you aware that the number of visits to a doctor by patients in the State of Maryland amounted to 20% being done at the Johns Hopkins Hospital. This may still be of no concern to you, however I am perfectly sure that this figure will continue to rise as the years go on. Solutions to this problem within our communities do not seem to be forthcoming.

3,000 Hospitals Without Pharmacist

I am certain I could offer you many other reasons why pharmaceutical service in hospitals should be of concern to all pharmacists. However, maybe this brief summary of what is going on nationwide can set the stage now for our televised program and inspection of pharmaceutical service in a typical American hospital. To make it even more interesting, we will state that this typical American hospital has a pharmacist and pharmacy that are licensed, remembering very well that approximately 3,000 hospitals in the country have no pharmaceutical service by a pharmacist.

A camera is now focused on the pharmacy entrance at 6:00 P.M. or at 9:00 P.M. Because the pharmacist utilizes only pharmacists to help him prepare medication orders for patients, and because he is working a 48 to a 52 hour week, he is now leaving for home. You will notice that our camera shows physicians utilizing the hospital by admitting patients and visiting them and writing orders for medication. In fact, the average physician may utilize as many as 10 to 22 different medications per patient during a typical 10 to 11 day stay. But, remember the parmacist just left for home. Instead, the nursing supervisor is now approaching the door as she will do many times during this evening and night. The scene may be somewhat different in another hospital where the nurse will be utilizing a medication cabinet or a vending machine that will serve as the pharmacy department for the next 14 hours or until 8:00 A.M. when the pharmacist again arrives.

Hospital Pharmacy Practice

While we are in the pharmacy let us observe the practice of a pharmacist when he is there. Look at the prescriptions—they are not written by a physician. Oddly enough, they are really interpretations by a nursing person who may be a registered nurse, a licensed practical nurse, a nursing assistant, a ward clerk or even a nursing student. Note the way in which medication is dispensed in an injectable form. You will notice that many of the injectable medications dispensed require reconstitution because of drug stability. Who do you think will do this reconstitution? The pharmacist does not, because he is too preoccupied religiously typing labels for Mol-iron tablets and other routine oral medications. You will also notice that he is religiously interpretating the interpretations of nursing personnel. He is occupied each morning religiously filling up ward stock baskets for alcohol, Zephiran, surgical soap, aspirin tablets, etc.: Just this week the School of Nursing asked that he prepare lectures on pharmacology and pharmaceutical calculations for nursing students. Unfortunately, he had to turn this invitation down because dispensing chores keep him occupied most of the day.

Pharmacy on a Nursing Unit

Now let us move our cameras to a typical nursing unit and examine what is happening pharmaceutically on that unit. The first thing you will notice is that nurses, licensed practical nurses and ward clerks are all huddling around a physician's medication order sheet or chart and attempting to decipher and decode physician's medication orders. Remember that the PDR, as one example, contains well over 14,000 names for drugs, and the scribbling physician's use is not any better than what you see in community pharmacy. They will interpret this order for the pharmacist in most instances and the tricks of the trade are interesting indeed.

You will also notice that that conversation between the intern, medical student, resident or staff physician involves drug information. The nurse is being asked to recommend analgesic medication or laxative medication and information as to the sizes and strengths of various drug products available. In the teaching hospital this is an on-going chore of every registered nurse for the medical student and new intern. Notice the nurse who is preparing medication that is to be administered to the pediatric patients. This particular patient cannot consume solid dosage forms and the nurse is utilizing a motar and pestle and grinding the tablet down even though it is an enteric coated tablet. She is adding some orange juice or some jelly in order to make it palatable for the child. What is the resulting effect of this liquid vehicle upon the stability of the drug? She simply does not know.

Reconstituting Injectables

Notice that the nurse is reconstituting injectable antibiotics and that she is adding them to intravenous fluids. This occurs with 80% of the fluids that are utilized in a given hospital. You will notice that the package insert that comes with the drug tells her virtually nothing about the stability of this drug or its compatibility with the particular electrolyte solution utilized and its pH. If you watch closely you will notice that she is adding other drugs to that bottle. Again no consideration for its stability. Let us ask the nurse about this consideration. She points out that no precipitate has occurred, a color change is not evident, and there is no formation of gas. Therefore no chemical change must have occurred.

You will notice that the nurse labels this bottle with a piece of adhesive tape and a ball point pen. However, the antibiotics used have an eight hour dating after reconstitution and the multidose vial she reconstituted now tells us nothing about the concentration that it was diluted to, or the date when this was done. Would you believe that this is compounding? You will notice that the nurse is now drawing up two injectable medications into the same syringe for a patient. Both of these medications have been drawn up from a multiple dose vial, and not only is she unaware of the compatibility of the two medications in the syringe, she has also injected a portion of one into the multidose vial of the other so that not only may it be biologically contaminated, but it may also be chemically contaminated.

Note that the nurse who has been preparing the medication for the patients who require medication at 10:00 A.M. has been interrupted at least five times by various assistants she is responsible for on the nursing unit. She has also been interrupted by phone calls from various portions of the hospital and she repeatedly comes back and tries to pick up where she left off in preparing all the medication doses for the patients, who may number as high as 30 to 40 on her particular nursing unit. As she picks up her tray and walks down the hall to begin administering drugs not only is she interrupted many times, but she also stumbles on a wet floor or around a cart and the tablets which she has so meticulously placed in souffle paper cups have bounced around and been jarred. She must replace them into the cup and hopefully they are the correct medication in the correct cup.

Medication Errors

It is not that the nurse is not concerned about the possibilities of all of these errors, but she has heard many times that hospitals live each day with the fact that 12 to 18% of the doses administered are in error. One investigator points out that there is a medication error committed every hour in every hospital in the United States. The nurse is still concerned about this, but there appears to be nothing she can do about it. This is the best she can possibly offer the patients under the conditions she works. She points out to us that she has about 15 minutes in which to administer 90 doses of medications to approximately 30 patients. She must get back to the medication station so that she can inventory all of the patients medication orders and supplies in order to prepare requisitions by 3:00 P.M. so that the pharmacist may dispense them and send them back to her before the evening nurse relieves her. After all, it is

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very difficult getting nurses these days and the evening and night nurses simply will not be bothered with routine inventory supply functions. She must prepare at least 40 requisitions for drugs to the pharmacy and check over the inventory of approximately 70 floor stock drug items.

Narcotic Inventories

In addition, she must count each dose of narcotics with the nurse relieving her before she leaves the unit. This task in itself may require 15 to 20 minutes. If there is a discrepancy in the narcotic report, she knows that the director of nursing or the chief pharmacist will plague her with investigational reports of why there was a discrepancy in the narcotic count. We ask her approximately how much time does she, as an average head nurse, spend in the business of medication. She indicates that industrial engineering studies have been done in the hospital and that on an average the nurse spends approximately 30 to 40% of her time in some aspect of medication either inventoring them, requisitioning them, preparing doses, administering drugs and charting them or providing information to physicians about drugs and straightening out problems with the pharmacy. She shrugs her shoulders and says, "What else can you do?" and goes about her duties.

The nurse appears to be in a hurry to get back to the station because one of the staff physicians is waiting to give her a carton of investigational drugs labeled SKS 1432. He has an interesting case in which he is acting as a clinical investigator for a drug manufacturer for a new compound. She wants to take down all the details of this investigational drug for his patient, because she must make sure the evening and night nurses and the private duty nurses, who may need to be called upon for service, know something as to who is to receive the drug and who to call if any adverse effects are noted. She will restore the entire bulk of the drug in a medication cabinet. No, the pharmacy does not handle any investigational drugs because their workload is now beyond them and besides the pharmacist is not here in the evening or night to take care of these needs.

Investigational Drugs

Let us initiate a conversation with the staff physician who is interested in investigational drugs and see what he thinks about investigational drug handling. Interestingly enough he happens to be a psychiatrist who recently became very interested in lithium carbonate for manic depressives. Upon questioning him we found out that he utilizes his private secretary or nurse back in the office to prepare capsules of lithium carbonate for use in the hospital. He had talked it over with the hospital pharmacist, but unfortunately the pharmacist is in no position to devote the time required to make up 300 mg. lithium carbonate capsules by hand because of its unavailability from commercial drug sources. Yes, he believes the pharmacy should be in control of all investigational drugs and should be able to devote great attention to preparing dosage forms that are not commercially available when the drug is so very important.

No visit to this institution would be complete without a chat with the hospital's administrator. We ask him if he believes the nursing staff and medical staff is satisfied with the hospital's current pharmaceutical service. He indicates that he has countless memorandums and complaints on the subject and upon investigating this with the hospital's pharmacist he found that the only apparent solution to the problem is to hire more and more pharmacists. However, the pressure of the government and society through its third party agencies is growing stronger all the time to reduce hospital costs. The pharmacist has pointed out to him that pharmacists receive salaries currently of between $10,000 and $12,000 a year and that licensed pharmacists are required to dispense medication at all times. The number of pharmacists needed to provide a complete and total service is simply beyond the means of the pharmacy at the hospital at the present time.

Emergency and Outpatient Areas

As we leave the hospital we exit through its emergency room and outpatient clinic areas. No visit would be complete without a look at this controversial area. We pose a number of questions to the nurses and physicians working in the emergency room and outpatient clinic. They inform us that patients are utilizing the emergency room at a growing number each year because of the seeming unavailability of physicians on evenings, nights, weekends and holidays for routine and non-emergency medical care. As we chat with these folks we notice that the medication cabinets in these areas are stocked with hundreds of oral drugs. We ask the staff why this is so. The interns and nurses point out to us that it is foolhardy and ridiculous to attempt to treat patients on an outpatient basis or in an emergency room if at 10:00 o'clock at night or 3:00 in the morning the patient requires medication and the pharmacy is closed.

Ladies and gentlemen this is the dilemma—this is our problem—the medical profession wants competent and complete hospital pharmaceutical service. The nursing professional wants competent and complete pharmaceutical service. Hospital administration appears to want it and society wants it, but in most cases they cannot afford the cost.

III. Hospital Pharmacy Service and the Importance of Supportive Personnel

Obviously as with any other problem there are possible solutions and recommendations that can be made.

1. Hospital pharmacy has and must utilize supportive personnel in its practice and, furthermore, most formally train such individuals. Is pharmacy unique among the medical specialties in this respect? Of course not. Medicine has historically created more and more sub-professions and skills as its research and services has increased to society. Nursing has done the same and notice carefully that physicians and nurses have remained in control of these supportive people and specialties. Is a therapeutic measure, such as a prescription represents, any more or less important than a diagnostic test? For example, is the dosage of Warfarin Sodium any more or less important than the prothrombin time determination that is ordered for a patient. One goes with the other. However, a supportive person, formally trained and recognized, is used to perform the test, but the quality of the performance is under the scrutiny of the physician. The physician in charge is concerned with the validity of the test, its interpretation and many other professional judgemental factors for which he is solely responsible.

The radiologist physician has trained and delegated the mechanical and manipulative skills and responsibilities to supportive personnel called radiology technicians. They again are formally trained and recognized but again the professional and judgemental responsibilities rest with the radiologist physician. The nursing profession has done basically the same thing.

Pharmacy's decision to utilize non-supportive personnel is not unique and not a precedent in the modern administration of medical care and with the medical team approach. Frankly, how long are we going to defend our pharmaceutical monopoly on the basis of the repetitive and manipulative skills we perform, while meaningful and professionally challenging roles go by the wayside to be picked up by others? Let me emphasize that point with some basic questions. Do you realize that the nurse is compounding and labeling drugs?

Do you know that nurses and administrators are working together on solving drug distribution in hospitals? Do you know that physicians on hospital Pharmacy and Therapeutics Committees, and other research physicians, must gather their own drug usage data in hospitals in order to carry out drug efficiency studies and toxicity studies? Do you know that hospital outpatients clinic and emergency rooms perform the role of a dispensing pharmacy? Do you know that interns, residents and even clerical personnel staff poison control centers in the United States? Did you know that the nurse with the Physician's Desk Reference acts as one of the key consultants on drug information to physicians? Did you know that physicians and their technicians do their own product development because of the unavailability or disinterest of the pharmacy department?

Counseling Patients

What about the business of counseling of patients on drug use particularly outpatients? Like it or not, it is a fact that medical centers and patients are more frequently providing and expected to provide outpatient services. Essentially, every other medical service is provided in one place in one visit except that service which at times divides you and me professionally. Regardless of our debates on this point of outpatient pharmacy services, economics is not the sole reason medical centers provide outpatient pharmaceutical service. Regardless of our debates on this matter, society will receive what it demands; right or wrong; provided by a pharmacist or not.

How often do you and I counsel patients about the use of their prescriptions or about the use of other drugs concurrently with that prescription or other prescriptions? How often do we discuss the best "q.i.d." arrangement or the best meal time arrangement for the administration of the drug? How often do we discuss why refrigeration is fundamentally important to the effectiveness of a medication? My point here is very simple. The point is that *while we are religiously devoting our attention to the mechanical manipulative skills of dispensing prescriptions, we miss some of the real contributions this profession can make.*

Economic Factors

Let me also say something about the economics of my recommendation and allow me to utilize our own department as an example. Two thirds of our pharmacy staff of over sixty people are non-pharmacists or supportive personnel and in some way virtually everyone "handles drugs." The pharmacists payroll alone now exceeds $250,000 a year. If we were to have a pharmacist in each job where a drug package is handled, the payroll would more than double with no increase whatsoever in quality or quantity of pharmaceutical service. Do you realize the cost of staffing each hospital in this land 24 hours a day with nothing but pharmacists even if we had the pharmacists to provide? This of course leads me to talk about manpower.

Where in the world would we get the 3,000 pharmacists to staff all hospitals in the United States 24 hours a day even if we could afford that arrangement. And perhaps with that remark this is the time to say that community pharmacies could assume the role of pharmacists for small and medium size hospitals. And why not? Virtually each community in this country that can afford to have a hospital of any size usually also has a community pharmacy or two. Why waste this valuable resource? Virtually every physician has an office practice and a hospital practice. Is it not time that pharmacists also had the same? How many of us are prepared to approach the administrator of a smaller hospital with a convincing awareness of his problems and their solutions and a cost arrangement acceptable to him and profitable to us. But when you do this, you will soon realize, ever so quickly, that supportive personnel is an absolute necessity.

Unit Dose System

Now, for a moment, let me give you an example of a solution to some of the problems we viewed through this human television camera in the hospital. In our own department and in several hospitals in the United States the pharmacy department is turning to a *unit dose drug distribution system* as an answer to these problems. Basically described, this means the responsibility for providing the nurse with a finished dose of appropriately labeled medication immediately prior to the time it is necessary to administer that dose. The dose is thus in a form that requires no additional alteration in order to administer it, whether this be for oral, topical or injectable use.

The pharmacist receives his order for the medication immediately from a copy of the physician's order sheet on the patient's chart, and the charting of that medication is done by the pharmacy. We too are approaching this idea in our hospital and eventually it will lead to small satellite pharmacies throughout the entire hospital. The nurse will be relieved of all drug ordering, preparation, alteration and inventoring. Hopefully, because of the immediate presence of the pharmacist on the wards of the hospital, drug information will be sought from the pharmacist and not the nurse.

Pharmacy Personnel Requirements

However, if we are to assume the responsibility for preparing well over 300 doses of medication per day for 30 patients, I can assure you that it will not be a pharmacist who will stand and prepare each dose of medication for every patient at all times. He will be directly responsible for the accuracy of the system, but I can assure you that supportive personnel will be utilized. In order to provide such a system for only 200 patients in the pediatric area of the hospital, it will require initially at least three pharmacists and six so called supportive personnel. Please note that we are approximately a 1200 bed hospital.

This description of the number and types of people needed to bring a solution to the problems we saw in the hospital has not taken into account the pharmacist and supportive personnel required in manufacturing, prepackaging, purchasing and inventory control. If you are disturbed by the fact it will be supportive personnel who prepare doses for each patient let me point out some interesting statistics to you. If the data is correct that 30 to 40% of prescription medications is only marketed to hospitals and related institutions, then, of course, 60 to 70% must be utilized in the community and self administered or administered by laymen.

Let me point out, also, that because of the extreme nursing shortage in the United States, that it is not the RN who is currently administering drugs, but in fact is a licensed practical nurse, a nursing assistant or an orderly (as we used to call them) and others. There is no precedent in this proposal or methodology, but, in fact, with properly trained supportive personnel there will be a vast improvement over the 12 to 18% medication error rate we now experience or believe we experience in hospitals. I should like to make a second recommendation:

Total Control by Pharmacists

2. Under no conditions could I accept the situation from both a legal and moral point of view, in which the pharmacy profession was not totally in control of the utilization, training and certification of supportive personnel.

I believe that in the utilization of supportive personnel pharmacists, as in other health specialties, must be responsible for delineating the functions of supportive personnel and for supervising their activities. I strongly believe that it should be the pharmacy profession itself who is responsible for the training of such individuals and not the federal government, and not unilaterally by so called community colleges. I am concerned as I read the literature that it is only a matter of time before the federal government through its agencies will go beyond the armed forces training program for pharmacy technicians and will enter the arena of training pharmaceutical technicians or supportive personnel. I believe that the profession must earnestly come to grips with this matter and it must come up with the answers to this problem before society finds an answer for us. Society is not going to listen to our arguments when they are based upon job protection and our personal economics. Our arguments against the use of supportive personnel must be based only on the principles embodied in the following three questions:

1. What is the effect on the quality of service provided to society?
2. What is the effect of the cost of pharmaceutical service to society?
3. What is the effect on the quantity of service provided to society?

Whether you agree or disagree with my thoughts on this subject, I have only one request to make: that we, as pharmacists, settle this issue and settle it quickly, or as with other issues, someone else will settle it for us.

Draft May Be Postponed To Complete Internship

On April 24, 1970, the American Pharmaceutical Association communicated with the state pharmaceutical association executives concerning President Nixon's Executive Order eliminating occupational deferments. Since graduates meeting their internship requirements were protected from the draft by occupational deferments, President Nixon's announcement had an immediate effect on students graduating subsequent to April 23, 1970. APhA wrote the Director, Selective Service System, asking for a national policy authorizing local draft boards to postpone the induction of graduating pharmacists until after they had met state licensing requirements.

In response to its request, APhA received from the National Headquarters, Selective Service System, a copy of Local Board Memorandum Number 44 as amended May 15, 1970. The pertinent portion of that memorandum reads as follows:

"State Boards of Pharmacy include a period of work as an intern as a prerequisite to qualification for examination. Whenever a registrant who has graduated from a school or college of pharmacy is ordered to report for induction, *the local board shall postpone* his induction until completion of the required internship and examination, provided that the intern period does not exceed twelve months and the registrant takes the next scheduled examination following his internship." (Emphasis added)

Methadone Maintenance Regulations Proposed

The Food and Drug Administration has proposed regulations governing the distribution and use of methadone in community drug addict rehabilitation programs. Methadone is a narcotic drug similar to heroin and morphine. FDA's regulations seek to control the investigational use of methadone, which amounts to the substitution of one form of addiction for another, while the patient undergoes various therapeutic treatments.

The proposed regulations, published in the June 11, 1970 *Federal Register,* include criteria and guidelines that FDA regards as acceptable for conducting research in this area. Included in the guidelines are outlines of the method of selection of subjects, treatment procedures, record-keeping, special procedures, terminations of participants and evaluation of results.

Prior to the use of methadone in the maintenance treatment of narcotic addicts, advance approval of both the Food and Drug Administration and the Bureau of Narcotics and Dangerous Drugs is required. Approval will be based on a review of a Notice of Claimed Investigational Exemption for a New Drug submitted to the FDA and reviewed by both agencies.

Hospital pharmacists are urged to review the use of methadone in their hospitals in light of the new guidelines.

Maryland's FAIR Plan

Vandalism and Malicious Mischief Coverages Available

By Newton I. Steers, Jr.

Drugstores and other businesses in Maryland are now assured of the availability of insurance covering vandalism and malicious mischief, through an expansion of the Maryland FAIR Plan enacted by our State Legislature this year.

As of July 1, the Joint Insurance Association (JIA) which administers the Maryland FAIR (Fair Access to Insurance Requirements) Plan, will offer additional kinds of "essential property insurance" coverage to businesses and homes in FAIR Plan areas. Vandalism and malicious mischief (V and MM) have been added to the fire and extended coverages originally available.

The FAIR Plan was designed to help those who have been refused essential property insurance in certain urban areas because of conditions beyond the control of the property owner, such as a deteriorated neighborhood, or because the area was thought to be riot prone. If your insurance company will not provide you with V and MM, you may wish to explore the availability of these coverages through the FAIR Plan. The JIA is on the fifth floor at 1 East Redwood Street, Baltimore, Md. 21202, and its telephone number is 539-6808. Application forms are available from your agent, or from the Plan office.

To obtain V and MM coverage through the Plan, however, it will be necessary for you to replace your fire and extended coverage insurance with one of the Plan's "service insurers."

What are "Service Insurers"?

The term "service insurers" refers to seventeen of the largest companies writing fire insurance in Maryland. The FAIR Plan, as it operates in our State, provides that each risk accepted in the FAIR Plan will be serviced by an individual company and carried on its books as if it were an ordinary transaction, but subject to proportionate sharing of any ultimate profit or loss by all the insurers in this State. The premiums are paid directly into the JIA, creating a "pool." Any individual company may choose to be a "service insurer" and, if it does so, the JIA pays a set percentage of the premium to that company for the service it provides. The amount paid is intended only to equal the costs of servicing that risk. In addition the JIA reimburses the service insurer for any claim paid by it. The payments, apart from claims paid, are scaled in such a manner that the service insurers do not make any profit from their function—which they are performing in behalf of the entire industry. This is indicated by the fact that only 17 of the companies have chosen to become service insurers. Any other company may become a service insurer any time it wishes, simply by asking to be so designated.

If the losses paid by the JIA in the above manner exceed the premiums received over an extended period, then *all* companies (not just service insurers) will be assessed to cover those losses in proportion to the volume of their regular business. If the losses paid become substantially less than the premiums received over an extended period, then I will require the JIA to adjust the FAIR Plan rates downward.

Rates and Surcharges

When the Plan began, the industry requested permission to impose surcharges on the fire and extended coverage rates as high as 400% over the standard rates. I rejected that request but did approve an amended request for a maximum rate which could result in no more than a 200% surcharge.

I would emphasize that generally no surcharge is applicable to any building in reasonably good condition, which is not being abused—even though it might be in an area thought to be riot-prone. Any property owner may eliminate all surcharges by eliminating all deficiencies, a clear statement of which must be provided to the insured on request.

Vandalism and malicious mischief rates in the FAIR Plan are now being developed by the JIA and will be submitted to my office for approval in the near future. The law requires me to approve rates which are neither excessive, inadequate nor unfairly discriminatory and I will approve rates for the V and MM coverages only if they meet those criteria.

What About Burglary and Theft Insurance?

Burglary and theft coverages are not now available under the FAIR Plan. However, the Federal law, pursuant to which our Plan was developed, allows the Secretary of Housing and Urban Development to include these types in the future—and he may do so. But they are not included at this time. If you think they should be, you should write to Secretary George Romney, HUD, Washington, D.C. 20410.

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Pharmacy—An Institution And A National Resource

by George P. Hager

Exerpted from the Second Annual A. G. DuMez Memorial Lecture given by Dr. George P. Hager, Dean, School of Pharmacy, University of North Carolina on November 4, 1969 *at the Health Sciences Library Auditorium, University of Maryland. The lecture is a memorial to Dr. A. G. DuMez, Dean of the School of Pharmacy, University of Md.,* 1926-48, *a distinguished educator and leader in pharmacy in Md., the U.S. and internationally.*

The five-year curriculum for the professional practice of pharmacy came into being at a time when society's need for the pharmacist's manipulative skills were still foremost in the minds of the planners. When the groundwork of the five-year curriculum was being laid, the pharmacist's role in medical care and community health—his felicity and security—his professional standing in society—depended primarily on what he did with his hands.

Unfortunately — or, rather, indeed, *fortunately* — our ultimate objective of manipulative perfection has undergone a serious erosion during the same twenty-year period in which pharmaceutical education conceived, bore, and nurtured the five-year curriculum to the robust adult it is today. Some of our short-sighted colleagues, with their vision circumscribed to encompass only the apparently unimpressive counting and pouring manipulative *operations* involved in our drug distributive *functions,* are now propagating the cliche that pharmacists are "overeducated and underutilized." One pharmacy dean was recently quoted ("The Green Sheet," 18, No. 38, September 22, 1969) as telling his state pharmaceutical association that the five-year program is "too long for retail pharmacists and too short to produce the drug expert envisioned by some." In fairness to the author of this statement, I must confess that I have not seen the context. Therefore, I challenge only the quoted statement. I challenge it first because it implies that drug expertise is an all-or-none phenomenon. I further challenge it on the basis of its implication that the "retail pharmacist"—the pharmacist privately practicing his profession in a community—is not or is not to be a drug expert in any degree.

One degree of drug expertise is required by the clinical pharmacologist in accordance with his *function* of designing the highly sophisticated protocols for clinical experiments with investigational new drugs and with his *function* of evaluating the results on a statistically sound basis. A different—but no less necessary—degree on drug expertise is required by the community pharmacist and the hospital pharmacist in accordance with *their functions.*

But what are the pharmacist's *functions?* There is no question that the procurement, storage, dispensing, and even the occasional compounding of drug products constitute an important *function* of the pharmacist today—the *drug distributive function.* But the *operations* through which the pharmacist performs his *drug distributive function* have become less and less impressive. Instead of macerating and percolating, he now orders drug products in finished form from wholesalers and manufacturers. Instead of triturating and emulsifying, he counts and pours. Instead of wrapping with the neatest fold and the neatest bow possible, he sometimes just bags and staples. Many of the *operations* mediating the pharmacists' drug distributive function probably could be automated. From this monolithic point of view, one logically deduces that a drug expert is not needed for the modern drug distributive operation and that the five-year program is "too long for retail pharmacists." Would not any educational program be too long for an *operation* circumscribed in this way? Simply returning to a four-year curriculum is an illogical conclusion even with respect to the short-sighted premise upon which it based.

The *drug distributive function* and the corresponding *operations* are, however, far more important in patient care and community health than they appear to be on the surface. The *drug distributive function*—even with the manifestly unsophisticated operation through which it is performed—provides the occasion—the rich opportunity—for the pharmacist's *other functions.*

As the pharmacist distributes drugs, he has the opportunity to monitor and control their utilization. He is the ultimate guardian against medication error. He has the first and clearest insight into problems of drug abuse and drug misuse. In short, the *drug distribution operation* provides the occasion for the pharmacist to perform his *drug monitoring and control functions.*

Moreover, as the pharmacist distributes drugs, he has the opportunity to explain the prescriber's directions and to reinforce the physician's will that they be followed accurately and faithfully. The pharmacist performs his "*follow-up*" *function* not only when handling the original order but especially on the occasions when the order is refilled.

Furthermore, as the pharmacist distributes drugs, he has an excellent opportunity to discern his patron's health or medical care problems at an early stage in their development. Perhaps, the pharmacist's *referral* or *triage function* is most seriously needed by the large self-medicating public.

Finally, as the pharmacist distributes drugs, he has many excellent opportunities to exercise his *communicative functions* for the benefit of his patrons or the patients he shares with physicians and other members of the health team. For example of the pharmacist's varied communicative functions, it should be pointed out that the physician's knowledge of drugs is an informative bank which he analizes and from which he retrieves information relevant to the patient's need for drug therapy. The pharmacist's knowledge of drugs is also an information bank—rich in the pharmacology, toxicology, and medicinal chemistry of a wide range of drug products—which he analyzes and from which he retrieves information relevant to the patient's need for drug therapy. The physician's information bank and the pharmacist's information bank are by no means identical though they may overlap in a significant degree. The most rational drug therapy decision is the negotiated decision that results when the physician and the pharmacist "put their heads together." *Two* information banks and the operation of *two* analysis and retrieval systems are far better than either one alone especially since neither involves a "blockhead." Collaborating with prescribers in rational drug therapy decision-making, counselling patrons in proper use of drugs, educating the public on matters related to their health are all operations of the pharmacist's *communicative function.* They operate in concert with his *drug distributive function.*

Are pharmacists "overeducated and underutilized" with respect to many of the operations through which he performs his *drug distributive function?* Yes! Without any doubt whatever. But the drug distributive operations—however some may deplore them—are the occasions, the rich opportunities, for the pharmacist's performance of his *other functions*: his monitoring and control functions, his referral function, his follow-up function, his communicative functions. Let us not be misled by those who stare blindly at one tree only, a somewhat scrawny tree at that. Rather let us broaden our vision to encompass the whole forest.

In the past, we have been preoccupied almost exclusively with our students' manipulative and cognitive skills. Even though the need for their more complex manipulative skills has declined, we have continued to stress all of the mechanical operations involved in drug product production, prescription compounding, etc. Students have been spending six hours per week throughout a full year making pharmaceutical preparations of all types, including some that have been long obsolete. Then they have spent six hours a week throughout a following year making much the same preparations in dispensing pharmacy. The cognitive skills of our students have also been developed to a very high level—even to the point where some incorrectly affirm that pharmacists are overeducated. We have required the students to commit to memory much information and data to which they have ready access in the reference books always available to them. We have failed miserably, however, in motivating our students to apply their manipulative and cognitive skills in the performance of functions that are essential for proper medical care and good community health. We have neglected their "balancing social and humanistic perceptions." We have not developed their affective or attitudinal skills. And pharmacy, as a profession, has suffered seriously.

The gap in the education of the pharmacist will be bridged by clinical pharmacy training and experience. Through clinical pharmacy, the student becomes keenly aware of the physicians who use drugs for a purpose and keenly aware of patients who take drugs to satisfy a need. A keen awareness of these personalities that are so intimately involved in the practice of pharmacy equates with the "balancing social and humanistic perceptions" with which the health professional must be endowed.

The hospital is the principal laboratory for clinical pharmacy instruction. In the hospital, the pharmacy student gets close to the bedside of the patient elbow-to-elbow with other members of the health team. The pharmacy student has proved to be a welcome addition to the team. A Medication Assistants Program was started at The University of North Carolina, somewhat fortuitiously, in the summer of 1967. At that time, the head of nursing expressed a need for rising seniors in pharmacy who might help to relieve personnel shortages in the Hospital. Four pharmacy students worked in the Hospital that summer. The value of their pharmacy backgrounds was apparent and the results of the experiment were very encouraging. During the following summer, 1968, 35 pharmacy students worked in the Hospital in a Medication Assistants Program that was developed by Mr. Fred M. Eckel. During the summer of 1969, 78 students worked as Medication Assistants: 60 at North Carolina Memorial Hospital and 18 at Duke University Hospital.

The Medication Assistants Program has emerged as a pharmacy clerkship parallel to the clerkship served by students of medicine. The pharmacy student, in his clerkship, administers drugs to patients, takes vital signs, and handles all of the pharmaceutical aspects of patient care under appropriate supervision. A major revision of the curriculum in basic pharmaceutics courses (preparative pharmacy, dispensing pharmacy, and pharmaceutical specialties) is now being made to prepare students for meaningful clinical pharmacy courses and clinical experience in the final year of the curriculum. The N. C. Board of Pharmacy now accepts experience as a Medication Assistant as a substitute for up to six months of the internship requirement for licensure as a Registered Pharmacist.

All senior students are now receiving some instruction in clinical pharmacy including, in a limited way, the experience of the Medication Assistant. By substituting experience in the hospitals for part of the laboratory time previously devoted to dispensing pharmacy, a larger number of students can be accommodated and with enrichment of their training (including the preparation of I-V additives in the clinical setting). A major feature of the program consists of conferences of the participants, the clinical pharmacy staff, *and* members of the faculty from all divisions. Attendance at the conferences has also proven to be a very beneficial experience for practicing pharmacists (some of them have been involved as part-time instructors in dispensing pharmacy). This may prove to be an excellent procedure for continuing education in clinical pharmacy for practicing pharmacists.

There is no question that clinical pharmacy and the pharmacy clerkship constitute a new and very important dimension in pharmaceutical education — the affective (attitudinal) training of pharmacy students. This training unquestionably is essential for the pharmacist's full application of his manipulative skills and cognitive skills in patient care and community health. Without appropriate "balancing social and humanistic perceptions," the pharmacist will continue to be "overeducated" and "underutilized" with respect to his traditional skills. Full utilization of pharmacy practitioners *in their professional capacities* will come about only as they are motivated toward intimate involvement in patient care and community health and, through first hand experience, come to the realization of the significance of their role on the health team. Under these circumstances, they will perform diligently the all-important monitoring, control, referral, follow-up, and communicative functions in concert with their drug distributive operations.

L-DOPA—A New Era in Pharmacotherapy for Parkinson's Disease

Adapted from "Pharmacotherapy for Parkinson's Disease: A New Era" by William W. Hofmann, M.D. and Leo E. Hollister, M.D.
Dr. Hofmann is an Associate Professor of Neurology at the Stanford University School of Medicine and Staff Neurologist at the Veterans Administration Hospital in Palo Alto. Dr. Hollister is a member of the Editorial board of "Pharmacology for Physicians" and a well-known clinical psychopharmacologist.

For three quarters of a century, anticholinergic drugs have been used empirically in Parkinson's disease. Within the past 15 years, as our understanding of the disease has increased, a new treatment has been developed on the basis of the concept of replacing in affected brain cells a deficient biogenic amine, dopamine. Curiously, the impetus for this new treatment stemmed from an adverse effect of drugs used for treating a completely different disorder.

Background

In 1960, chemical examination of the brains of 40 patients with Parkinson's disease revealed a marked decrease in dopamine content in the striatum as well as certain other areas of the brain. This critical discovery pointed the way to the dopamine hypothesis, which explained simultaneously the biochemical pathology of the naturally occuring disease as well as the mechanism of an unusual neurologic side effect of drug therapy.

Over the next several years attempts were made to treat patients with Parkinson's disease with dihydroxyphenylalamine (dopa). The blood-brain barrier was impervious to dopamine itself, but allowed its precursor, dopa, to pass. Because the brain has the necessary enzymatic system to convert this precursor to dopamine, giving dopa was a logical approach for increasing dopamine content in the brain. Despite reports of transitory alleviation of symptoms by either oral or intravenous administration of dopa to patients with Parkinson's disease, the relatively small effect or brief duration of action discouraged most workers. The persistence of one group of workers, who finally achieved the success that had eluded others, led them to try extraordinarily high doses of dopa. Results were far beyond those attained previously by conventional drug therapy. A basic principle of pharmacology had almost been overlooked: no drug should be considered a failure until it has been used in adequate doses.

Research Improvements

As with any new treatment, modifications have been made as clinical experience has increased:

1—Initially the racemic mixture of the dextro- and levo-isomers of dopa was used, primarily because of the greater expense of the active 1-isomer. Now only 1-dopa is used, and it is believed that its use has resulted in fewer of the untoward reactions initialy encountered.

2—The daily dosage schedule has been divided so that single doses stay small. Increments are added every other day until a maximum tolerated dosage or an arbitrary maximal dosage of 8 Gm. is reached. The average optimal dosage has averaged 5.8 Gm. daily; little improvement has been observed at dosages of less than 3 Gm.

3—Improvement may not be evident for as long as six weeks; an effective dosage level must be maintained for some time. Improvement may be progressive for long periods of time. Discontinuation of drug seldom results in relapse until several days and often not for several weeks. Symptoms reappear in a reverse order of their disappearance. Retreatment with the same schedule as initially used reverses relapses.

4—Nausea and vomiting, frequently limiting side effects, may be prevented by slow increments in dosage or by giving the drug with protein-containing foods.

5—Alpha-methyl-dopa hydrazine, a compound that blocks dopa decarboxylase peripherally but does not enter the brain, has been used to block conversion of 1-dopa to dopamine in the body so that a greater fraction of the dose reaches the central nervous system. At present, the proportion of 1-dopa given that enters the nervous system is no doubt minute, so that even a small increase might permit considerable reduction in the dosage of 1-dopa needed. Unfortunately, alpha-methyl-dopa hydrazine appears to be too toxic for widespread use.

6—Clinical evidence to date suggests that in some patients, combined treatment, i.e. the use of anticholinergic drugs along with l-dopa, is more effective than treatment with l-dopa alone.

Practical Considerations

Two serious problems with the use of l-dopa are the very large doses required and the consequential great cost of the drug. It seems absurd to administer grams of drug a day to achieve increments of milligrams or micrograms in the nervous system. Although initial attempts to find a way to reduce the dosage by selective dopa decarboxylase inhibition have not succeeded, this or some other approach will no doubt be pursued. Because of the large daily dosages required by patients, literally tons of l-dopa must now be produced yearly to meet the demand of only the most needy candidates for treatment.

There is some reason for administrators of government-sponsored health programs as well as other third party payers to become concerned with the costs involved in an l-dopa treatment program. First of all, at least one drug manufacturer is recommending to physicians that they hospitalize certain l-dopa patients for a two-week period in order to closely monitor dosage initiation. Secondly as was pointed out, the usual dose is in the 4 to 6 Gram category and is continued for life if indicated. Thus it is quite possible for a patient to use $500.00 worth of l-dopa per year if he is taking 6 Gm. a day and obtains a months supply at a time.*

At this stage of experience in the case of a treatment that must be maintained for the remainder of a patient's life, we do not know much about the long-term toxicity. Some patients are now on their third year of continued

---

*Based on a customary charges to third party payers at current cost.

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treatment with l-dopa without any major or life-threatening complication and, most encouraging, show little or no progression of the disease. One can only hope that this long overdue therapeutic advance will hold for this chronic disabling disorder.

Product Information

At the time of this writing, two manufacturer's are licensed to sell l-dopa (levodopa).** Roche Laboratories supplies their product under the name "LARODOPA" as pink, scored tablets containing 0.25 Gm. levodopa (imprinted Roche 57) or 0.5 Gm. levodopa (imprinted Roche 56) in bottles of 100 and 500. Also capsules containing 0.25 Gm. levodopa (pink and beige, imprinted Roche 55) or 0.5 Gm. levodopa (pink, imprinted Roche 54)—bottles of 100 and 500.

Eaton Laboratories supplies "DOPAR" brand of levodopa in opaque green capsules of 100 mg.; in opaque green and white capsules of 250 mg.; and in opaque green capsules of 500 mg. These are supplied in bottles containing 100 capsules.

DOSAGE. Initially 0.5 Gm. to 1 Gm. in 2 or more doses. The total daily dosage is then increased gradually in increments of 100 mg. to 750 mg. every 2 or 3 days as tolerated. The usual daily dosage range is from 4 to 6 Gm. administered orally in 3 or more doses with food. The daily dosage should not exceed 8 Gm. Optimal therapeutic dosage is usually reached in 6 to 8 weeks.

Adverse reactions are listed in detail in the manufacturer's package insert.

**Nutritional Biochemical Laboratories is expected to be a third supplier of levodopa soon. They have been distributing experimental supplies for study.

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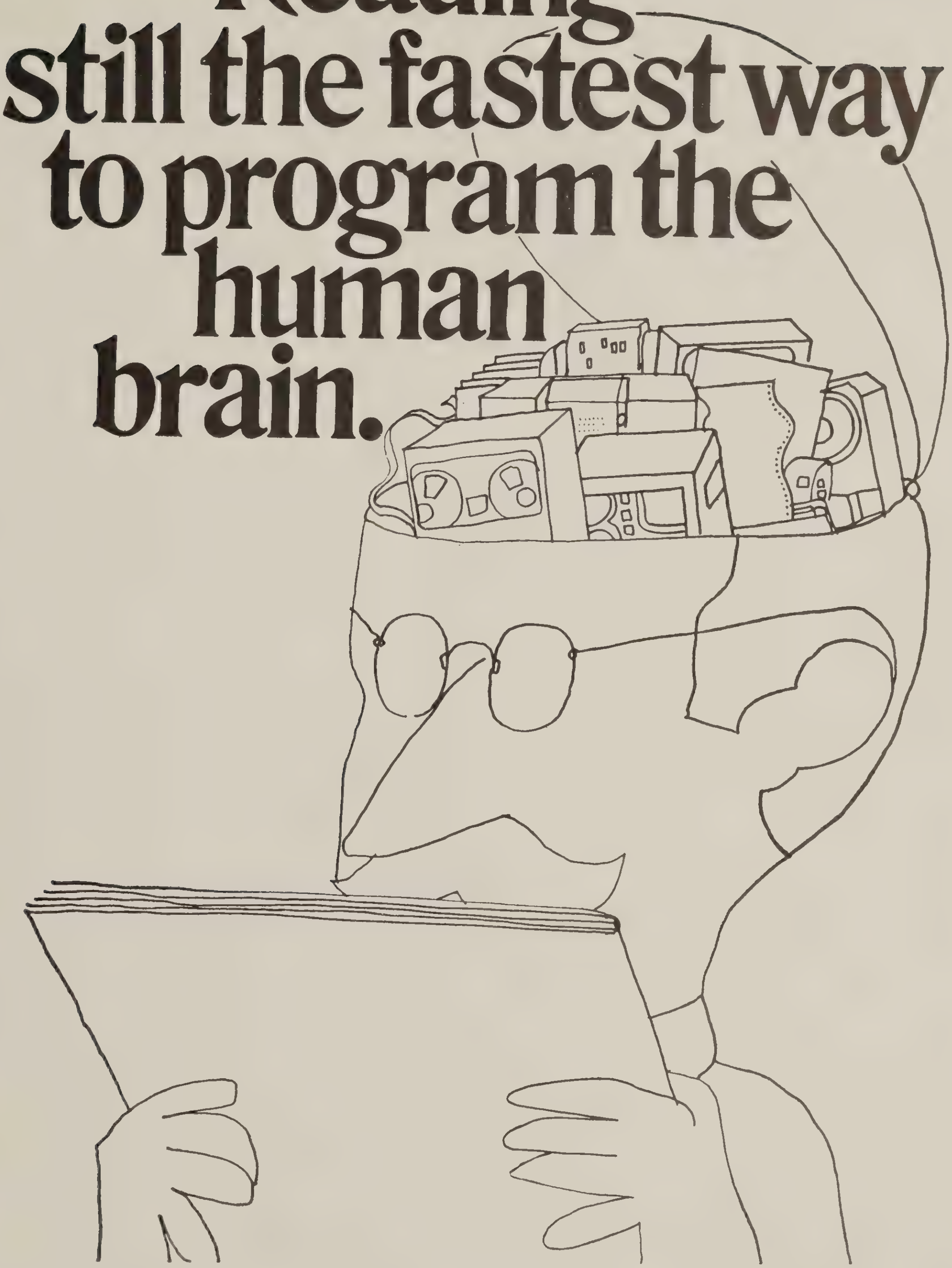
The Prince Georges-Montgomery County Pharmaceutical Association sponsored a booth at the Montgomery County Fair held in Gaithersburg, Maryland, the week of August 24, 1970. The exhibit served as a Public Information Center and featured "Pharmacy Careers," "Drug Abuse" and "Narcotics" information. Shown manning the booth is Salvatore J. Latona of Mount Rainier, a past president of the group. Chairman of the project was Samuel Morris.

Reading is still the fastest way to program the human brain.



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MPhA–LAMPA–TAMPA

CHESTNUT RIDGE COUNTRY CLUB

Thursday, October 15

IMPORTANT AGENDA:

AFFILIATION

AMENDMENTS TO CONSTITUTION AND BY-LAWS

RESOLUTIONS

LEGISLATIVE PROGRAM

Volume 46 SEPTEMBER 1970 Number 9

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Editorial . . .

First Things First!

There are a thousand and one critical issues crying for attention in pharmacy. All of us can come up with a thick catalog of problems to be tackled, programs to be launched, laws to be enacted, education to be offered and adversaries to be overcome.

Many of these issues are completely or partially dependent on forces *outside* of pharmacy for their resolution in a manner satisfactory to our profession, as well as that of the public interest. Some examples are: ownership of pharmacies solely by licensed pharmacists, restriction of the sale of non-prescription medication to pharmacies, national health insurance and the use of non-pharmacists as supportive pharmaceutical personnel.

In order to progress toward the achievement of the legitimate professional and economic aspirations of pharmacists, whether their achievement can be influenced by the profession's actions or not, rests on the posture of pharmacy's organizational structure. Here is the crucial question: do pharmacists finally comprehend that the success of other professions and vocations depends on a foundation of unified organized strength?

Pharmacy's Number One priority, then, is a federated or affiliated relationship between the local pharmaceutical groups with the Maryland Pharmaceutical Association and the MPhA with the American Pharmaceutical Association.

At the 88th Annual Meeting (Convention) the MPhA approved the recommendations of our APhA Affiliation Study Committee that the MPhA affiliate with APhA. The second reading of the Amendment to the MPhA Constitution, requiring APhA memberhsip for all *new* members will be voted on at the Fall Regional Meeting on October 15th.

All members are urged to express their views by attending the meeting, or in writing.

Yes, first things first! Let us forge a strong unified structure through affiliation with APhA. There are many mutual benefits. (See Article, "Affiliation with the American Pharmaceutical Association—Why?" in this issue.)

But the most important reason for affiliation is that this will be an essential concrete step to strength. Then we can say to all: "APhA truly represents the overwhelming majority of pharmacists in the United States and the Maryland Pharmaceutical Association represents the overwhelming majority of pharmacists in Maryland. *We speak for pharmacy!*"

Jaycees Launch Drug Abuse Project

MPhA member Chester Price gave an orientation talk on drug abuse at a recent meeting of the Dundalk Jaycees as the group prepared to kick-off their upcoming community drug abuse project. As part of their program, the Jaycees have prepared a presentation on drug abuse and will present it to any interested audience.

Proposed Amendments To Constitution and By-Laws

As approved at first reading July 15, 1970 *at Annual Meeting, Atlantic City, N. J. To be presented for second and final reading at the Maryland Pharmaceutical Association Fall Regional Meeting, October* 15, 1970, *Chestnut Ridge Country Club.*

1. Article III of the Constitution—Types of Membership

Section 3. ACTIVE MEMBERS: Any pharmacist of good professional standing and who is a member of the American Pharmaceutical Association, shall be eligible to active membership in this ASSOCIATION, upon subscribing to the constitution and by-laws of this ASSOCIATION, and payment of dues for the current year, and shall be entitled to all the rights, privileges and benefits of the ASSOCIATION. For the purpose of the ASSOCIATION Constitution and By-Laws, "pharmacist" shall mean an individual who holds a valid license to practice pharmacy or who holds an earned degree in pharmacy.

Applications shall be made on the form prescribed by the Board of Trustees and shall be approved by the vote of a majority of the Board of Trustees. None of the above qualifications shall change the status of any one who is an Active Member at this time and who maintains continuous membership in the ASSOCIATION.

2. Article IV of the Constitution—To read as follows:

Officers and Board of Trustees

1. The Board of Trustees shall consist of fifteen (15) members which shall include the following Officers: President, the President-elect, the immediate Past President, who shall serve as its Chairman, the Vice President, the Speaker of the House of Delegates, the Executive Director (Ex-Officio,) the Treasurer, six (6) elected Trustees and two members ex-officio without vote: the Dean of the University of Maryland School of Pharmacy, and the Secretary of the Maryland Board of Pharmacy.

Duties:

To act for the ASSOCIATION in the interim between meetings of the House of Delegates, act on application for membership, ratify appointment of Committees; supervise all property funds and finances; approve annual budget; appoint the Executive Director with the advice and consent of House of Delegates; and such other duties as may be specified in the By-Laws.

2. Elected Trustees will serve for three-year (3-year) terms, staggered, two elected each year.

3. Election shall be by mail ballot within sixty (60) days after nominations have been certified by the House of Delegates.

4. The Board of Trustees shall meet at the call of the Chairman, President or majority of Trustees.

5. Quorum: Seven (7) members shall constitute a quorum.

3. Article II of By-Laws:

In the absence of the President, or his inability to act, his duties shall devolve upon the following officers, in this order: President-Elect, Vice President, Chairman of the Board of Trustees.

4. Article V of the By-Laws

House of Delegates

Duties

1. It shall interpret the objectives of the ASSOCIATION.

2. It shall serve as the legislative and policy making body.

3. It shall consider all appropriate proposals emanating from the Board of Trustees, Associated Sub-Divisions, Standing and Special Committees, Affiliated Organizations, Recognized Organizations, Delegates and Delegates Ex-Officio, and all local Associations.

4. It shall adopt By-Laws for the conduct of its business which shall not be inconsistent with the Constitution and ASSOCIATION By-Laws.

5. It shall transact all general business of the ASSOCIATION not otherwise specified in the ASSOCIATION Constitution and By-Laws.

Election or Appointment of Delegates

1. Delegates shall be appointed (or elected) by each sub-division, affiliated and recognized organization for the period from Convention to Convention.

Officers—(of the House of Delegates)

Officers shall be a Speaker and Vice Speaker, elected by the Delegates, and a Secretary. THE ASSOCIATION Executive Director shall serve as Secretary of the House of Delegates.

Composition

The House of Delegates shall consist of accredited representatives of the following organizations, apportioned as follows:

1. Affiliated Organizations: (A recognized organization which has entered into an affiliation agreement with the Board of Trustees) two (2) Delegates plus one (1) Delegate for each twenty-five (25) ASSOCIATION Members or major fraction thereof.

2. Recognized Organizations: (An Organization, the majority of the members of which are pharmacists, and which carries on activities designed to encourage and promote public health and the advancement of pharmacy may be designated as a Recognized Organization by the Board of Trustees. The designation as a Recognized Organization may be terminated by the House of Delegates upon recommendation of the Board of Trustees) one (1) Delegate plus one (1) Delegate for each fifty (50) MPhA Members or major fraction thereof.

3. The University of Maryland School of Pharmacy: one (1) Delegate.

4. University of Maryland School of Pharmacy, Joint APhA-MPhA Student Chapter: One (1) for each of the three (3) professional years.

5. Officers and Board of Trustees and the three Immediate Past Presidents shall be Delegates Ex-Officio with vote.

6. Alternate Delegates may be specified in advance or recognized by the House of Delegates.

7. Quorum: One-third (1/3) of the total Delegates of the House

5. Article VI of the By-Laws

Meetings

1. *Regular Meetings* — The House of Delegates shall meet at the Annual Meeting upon the call of the Speaker, or on written request of one-fourth (1/4) of the Delegates.

2. *Special Meetings*—of the House of Delegates may be called between Annual Meetings at the call of the Speaker, with the consent of the Board of Trustees, or upon written request of one-fourth (1/4) of the voting Delegates.

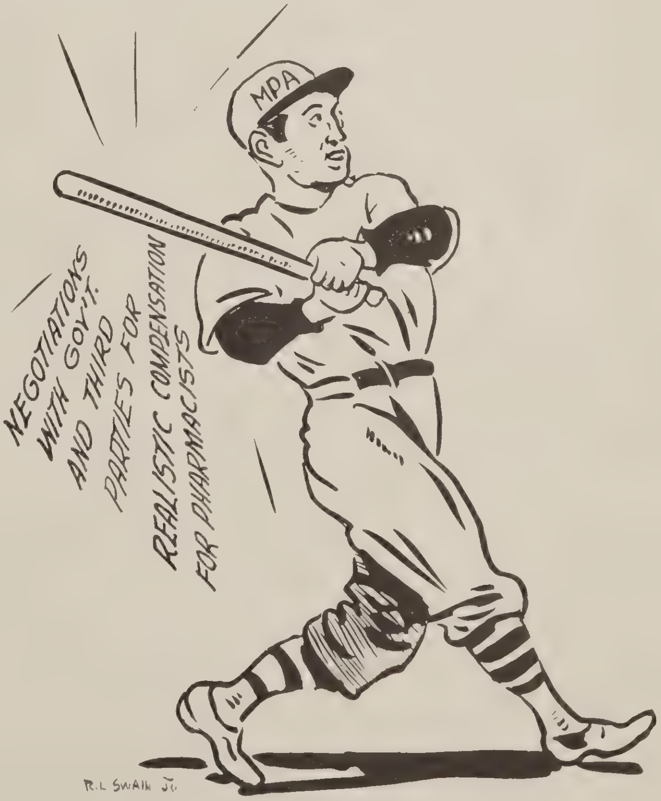
6. Article VII of the By-Laws—Board of Trustees—DELETE and renumber all articles.

7. Article IX of the By-Laws

Financial Administration

Section 5. Any member, whose dues shall be in arrears, as of *April 1st* of each year, shall after due notification from the Treasurer, lose his rights as a member.

8. All references to "Executive Committee" shall read "Board of Trustees." All reference to "Executive Secretary" shall read "Executive Director."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Maryland Board of Pharmacy News . . .

Pharmacy Changes . . .

The following are the pharmacy changes of the month of September:

New Pharmacies

Peoples Service Drug Store, Inc. No. 295, W. E. Pannill, President, 19194 Montgomery Village Avenue, Gaithersburg, Maryland 20760.

No Longer Operating As Pharmacies

McComas & Palmer Pharmacy, Samuel H. Cohen, President, 8642 Loch Raven Boulevard, Baltimore, Maryland 21204.

Manhattan Drug Company, Harvey Silberg, President, 1800 East Monument Street, Baltimore, Maryland 21205.

Milton Pharmacy, Inc., Marion R. Chodnicki, President, 35 North Milton Avenue, Baltimore, Maryland 21224.

Five-Fifty Pharmacy, Morton Kahn, 550 North Broadway, Baltimore, Maryland 21205.

Changes In Ownership, Address, Etc.

None

– NOTICE –

The Maryland Board of Pharmacy will conduct an examination for registration as Pharmacist at the School of Pharmacy, University of Maryland, 636 West Lombard Street, Baltimore, Maryland.

On Monday, Tuesday and Wednesday
November 2, 3 and 4, 1970.
The examination will begin at 8:00 a.m. each day.

Applications must be in the hands of the Board by Friday, October 23, 1970.

Letters to The Editor

September 15, 1970

Mr. Nathan Gruz
Maryland Pharmaceutical
Association
650 West Lombard Street
Baltimore, Maryland 21201

Dear Nat:

Just thought I would drop you a congratulatory note on the July issue of the Maryland Pharmacist, for its "chain store report." I hope that other associations will follow your lead in publishing not only economic and financial information on chain drug stores but other items as well.

Best personal regards.
Sincerely yours,
Michael Zagorac, Jr.
Director Public Affairs
National Association of Chain Drug Stores, Inc.

Secretary's Script . . .

NATIONAL PHARMACY WEEK

October 4-10

"RESPECT MEDICINES"

This year's theme for National Pharmacy Week—"Respect for Medicines"—is one that must be the attitude that pharmacists must inculcate in every patron *every* week of the year. In fact many health professionals, including pharmacists, physicians and nurses must be constantly reminded of the inherent toxic potential of *all* medication.

Display the National Pharmacy Week Poster upon receipt from MPhA. Counsel your patrons on safeguarding all drugs, following prescriber's directions and refraining from exchanging medication with friends and neighbors.

How about our pharmacies? Is mass display and self-service of drugs the way to elicit the response of "Respect Medicines?"

Is the promotion of OTC drugs in the windows and counters of pharmacies more in the public interest than the drug commercials on TV and radio, about which we hear much current criticism of from legislators, government officials and concerned citizens?

Shouldn't pharmacists be in the vanguard to protect the public from the promiscuous promotion of medication as the panacea of "pill popping" for our real and psychosomatic ills?

Is Discounting The Answer?

The MPhA Simon Solomon Pharmacy Economic Seminar will be held on Thursday, November 19, 1970 at the Warren House in Pikesville. The theme is "Survival for Pharmacy in the 1970's—Is Discounting the Answer?"

The morning session will consist of presentations by authorities in the discounting world who will tell it like it is. There will be an opportunity to learn what discounting is and is not, how to discount, when to discount and when not to discount.

Other viewpoints will be presented at lunch and in the afternoon session with Dr. Dean Leavitt, Associate Professor and Head of the Department of Administration, University of Maryland School of Pharmacy, and other speakers on "Professional Answers to Survival."

Product Changes Section

Geigy Pharmaceuticals

Package Size Deletions:
- Dulcolax tablets, 5 mg., box of 6
- Eurax Cream, 10% 20 Gm. tube
- Preludin Endurets, 75 mg., bottle of 1000

Product Deletions:
- Medomin tablets, 200 mg.
- Sterosan Cream
- Sterosan-hydrocortisone Ointment

Additions:
- Preludin Endurets, 75 mg., bottle of 500

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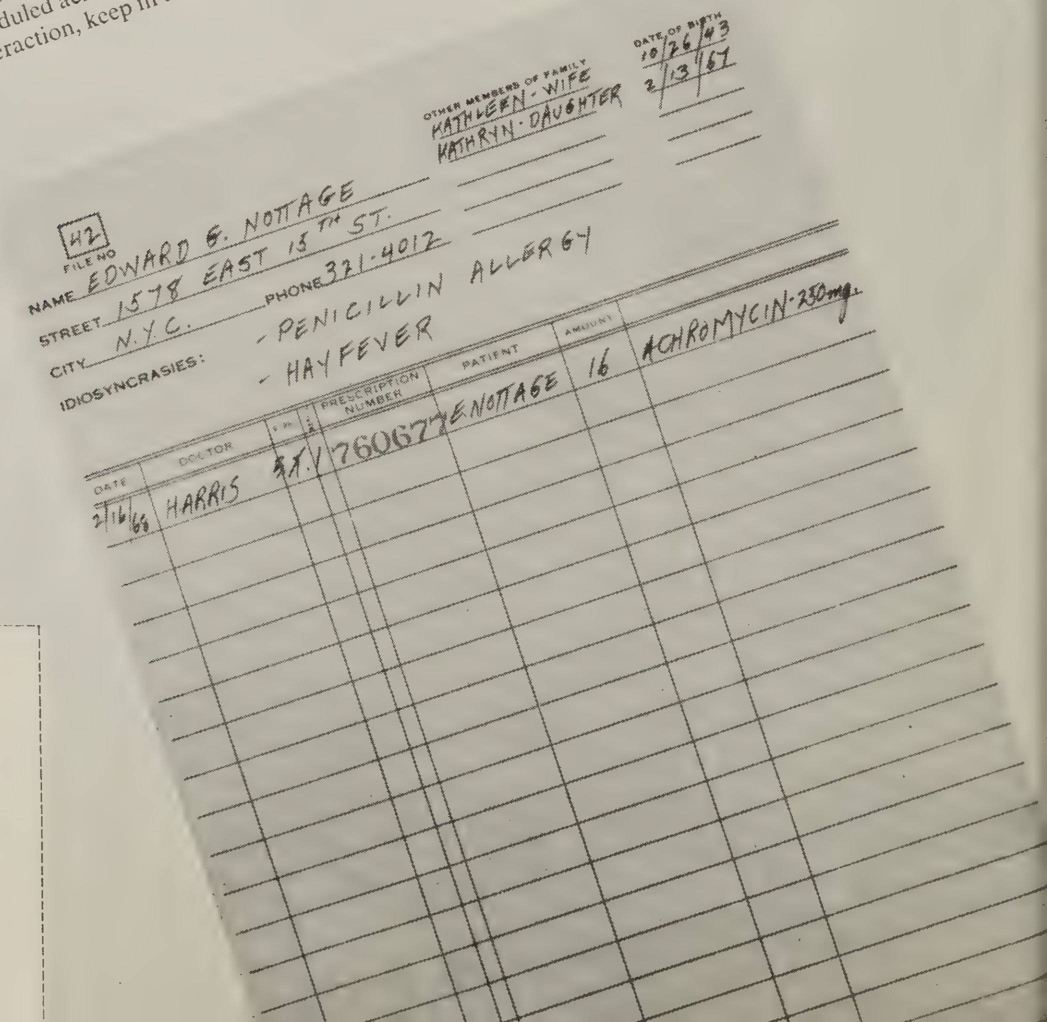
But even a pharmacist may be at a loss to help his customers unless he has readily at hand the necessary information about which patients are taking which drugs. That's the reason why Lederle will mail to you at your request a sample of a commercially available Family Record Form typical of many in use today. (Simply use the coupon below.) Only with records like these is a pharmacist prepared to advise in individual problems of drug interaction.

Because Lederle is vitally interested in broadening knowledge about this important subject, we have inaugurated a program of Drug Interaction Symposia in collaboration with Schools of Pharmacy, Pharmaceutical Associations and Medical Societies. Two symposia have been held—in Hartford, Connecticut and Binghamton, New York—and others are being scheduled across the country. To keep in touch with developments in Drug Interaction, keep in touch with Lederle.



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- HAYFEVER

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Senate Bill Number 883

Health Controlled Dangerous Substances

Excerpts of Senate Bill No. 883 have been mailed to all pharmacists in the State of Maryland. As a service to our members, we are supplying the following outline.

Section 279 contains four schedules of controlled dangerous substances.

SCHEDULE I

As Schedule I pertains to drugs which have no general accepted medical use in the United States (e.g. heroin, marihuana, mescaline), the drugs in this schedule will not be reprinted here.

SCHEDULE II

The drugs listed in Schedule II are the Class A narcotics and methamphetamine. Some examples are: alphaprodine (Nisentil), anileridine (Apodol, Leritine), fentanyl (Sublimaze), levorphanol (Levo-Dromoran), methadone (Amidone, Dolophine), pethidine (Demerol), phenazocine (Primadol), piminodine (Alvodine), and methamphetamine (Desoxyn, Methedrine).

No prescription for a Schedule II substance may be refilled.

SCHEDULE III

The drugs listed in Schedule III are the Class B narcotics and the stimulants and depressants. Schedule III also includes nalorphine (Nalline), a class M narcotic. Other examples of Schedule III drugs are: phenmetrazine (Preludin), methylphenidate (Ritalin), chloral betaine (Beta-chlor), chloral hydrate (Noctec, Somnos), ethchlorvynol (Placidyl), methyprylon (Noludar), and combination drugs containing amphetamines or barbiturates.

Prescriptions for drugs in Schedule III may not be refilled after six months or be refilled more than five times after the date of the original prescription.

SCHEDULE IV

Drugs in Schedule IV are those that are currently Class X narcotics. In addition to compliance with federal, state, and local laws which govern the dispensing of these drugs, a label bearing the dispenser's name and signature, his registration number, the date on which dispensed, and the purchaser's name must be affixed to the container.

Inventory Requirements

Complete inventory of all stocks in above schedules must be taken on the effective date of this Act and be retained for two years. A new inventory must be taken every 2 years thereafter at the time of the regular fiscal inventory.

The reader is referred to the original copy of the *excerpts* issued by the Division of Drug Control for complete information.

Because this law is so complex and unclear in parts, the State Department of Health is still awaiting clarification from the Attorney General on a number of points. Additional copies of pertinent sections of Senate Bill Number 883 are available from the MPhA office.

Obituaries . . .

James Edward Johnson

James Edward Johnson, member of the Maryland Pharmaceutical Association and a pharmacist for 34 years at Penn-Dol Pharmacy, died suddenly on July 30. He was born in Homestead, Pa. and earned his pharmacy degree from the University of Pennsylvania. He was also a member of BMPA, APhA, Chi Delta Mu and Omega Psi Phi fraternity. He is survived by his wife, Mrs. Mattie Johnson, a son, James Jr., and five sisters and three brothers.

Dr. Nathan Rudo

Dr. Nathan Rudo, 60, died in San Francisco, August 29, 1970. He was registered as an assistant pharmacist on July 15, 1929 and received his Ph. G. from the University of Maryland in 1930. He received his M. D. from the same institution in 1934. He was a pathologist at the Medical Center, San Francisco, and is survived by 2 sisters in Baltimore, Mrs. Vivian Grossman and Hilda Cooper. His brother "Ben" Rudo, who died in 1965, was also a pharmacist.

Dominic Felicetti

Dominic Felicetti, 45, partner in the Suburban Pharmacy, Hillside, Prince George's County, died of a sudden heart attack on August 17, 1970. He reciprocated from Virginia to Maryland in 1950.

J. Elmer Baker

J. Elmer Baker, age 80, a 1915 graduate of Philadelphia College of Pharmacy, who for 33 years, from 1920 to 1953 operated a pharmacy at West Salem and Potomac Streets in Hagerstown, died June 22. Mr. Baker was a member of the Hagerstown Water Board for 16 years.

Dr. S. Fred Marshall

Dr. S. Fred Marshall, age 75, a 1916 graduate of the University of Maryland School of Pharmacy, who operated a drug store in his native Hagerstown briefly before going on to receive A.B. and M.D. degrees from Johns Hopkins, 1921 and 1925, died in Massachusetts on July 2. Dr. Marshall was actively practicing surgery in Boston until his retirement.

Fenton L. Bachman

Fentoi L. Bachman, age 63, of Arlingto,n Virginia, who was a graduate of Pittsburgh College of Pharmacy, and operated a drug store in D.C. having reciprocated from Pennsylvania to Maryland in 1947, died in Washington County Hospital in Hagerstown on July 2.

Charles A. Youch

Charles A. Youch, age 55, formerly of Baltimore and Levittown, Pennsylvania, died in Moorestown, New Jersey on July 5.

Dr. George S. M. Kieffer

Dr. George S. M. Kieffer, age 89, oldest living graduate of Maryland College of Pharmacy (1900) died on July 9. Dr. Kieffer received his medical degree at the University of Maryland School of Medicine in 1903 and practiced in Baltimore and Baltimore County for 67 years.

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National Pharmacy Week

OCTOBER 4-10, 1970

PROCLAMATION

WHEREAS, the pharmacists of the State of Maryland are health professionals safeguarding and promoting the well-being of our citizens; and

WHEREAS, these pharmacists, under the leadership of the Maryland Pharmaceutical Association, give wholeheartedly of their time and talents to assure that pharmaceutical services and guidance are available to all; and

WHEREAS, National Pharmacy Week, under the auspices of the American Pharmaceutical Association, will be observed nationally during the week of October 4-10, 1970, to direct public attention to the need to "Respect Medicines," the theme of this year's observance; and

WHEREAS, the safe, effective use of medicines depends upon the physician, patient and pharmacist working together so that today's medicines can benefit the human body, not damage it;

NOW THEREFORE, I, Marvin Mandel Governor of the State of Maryland, do hereby proclaim the week of October 4-10, 1970, as National Pharmacy Week in our State and urge all our residents to recognize this week the services of our pharmacists, and to consult with them about the safe, effective use of today's medicines.

PROCLAMATION

By

MAYOR THOMAS J. D'ALESANDRO, III

Designating the Week of October 4-10, 1970

As

"National Pharmacy Week" in Baltimore

WHEREAS, the week of October 4-10, 1970, is being observed as "National Pharmacy Week" under the auspices of the American Pharmaceutical Association, the national professional society of pharmacists, and the pharmacists of Baltimore under the leadership of the Baltimore Metropolitan Pharmaceutical Association.

WHEREAS, the theme for this year's observance is "Respect Medicines;" and

WHEREAS, the safe, effective use of medicines depends upon the physician, patient and pharmacist working together so that today's medicines can benefit the human body, not damage it;

NOW, THEREFORE, I Thomas J. D'Alesandro, III, Mayor of the City of Baltimore, do hereby proclaim the week of October 4-10, 1970, as "NATIONAL PHARMACY WEEK" in our community, and I urge our citizens to consult with their pharmacist this week for advice and guidance on the safe, effective use of medicines.

Recommendations of the Legislative Committee

Maryland Pharmaceutical Association

Anthony G. Padussis, *Chairman*

To be presented at Fall Regional Meeting, October 15, 1970

1. Legislation or Regulation Permitting Operation of a pharmacy with the prescription department closed during a portion of the tota lhours open, with the pharmacist not on duty during such hours as the prescription department is closed.

RECOMMENDATIONS: (a) The Committee felt this issue should be studied further and that the opinions of more members should be obtained.

(b) In the meantime, opinions should also be obtained from the Board of Pharmacy and from Maryland Pharmaceutical Association Legal Counsel.

(c) Pertinent legislation on this subject in the states of Virginia, Florida, California, D.C., Ohio and other states should be studied as to approach and results obtained.

2. RECOMMENDATION: Legislation be sought for registration or permit to operate a pharmacy only in the name of a pharmacist, not pharmacy or corporation.

3. RECOMMENDATION: Legislation should be drafted for a "Commission on Pharmacy Discipline" modeled after the "Commission on Medical Discipline" now part of Maryland statutes.

4. RECOMMENDATION: Legislation should be sought for a "third class of drugs," i.e., a non-prescription drug deemed "dangerous" by a special "State Commission" would be available for sale only under the control of a pharmacist. Open display of drugs would be prohibited.

Heller and Briggs Elected to U.S.P.

Among those recently elected officers and members of the Board of Trustees of the U.S.P. Convention is Dr. William M. Heller of Maryland who was elected Secretary of the Board. Dr. Heller is the Executive Director and Secretary of the U.S.P. Convention and a member of MPhA. In addition, Dr. W. Paul Briggs, who received his M.S. at the University of Maryland, was re-elected Treasurer of the Convention, a post he has held since 1940.

Other officers elected at the April 10 session of the Convention are John H. Moyer, M.D., president and George E. Farrar, M.D., Vice-President.

At the same time, the Convention delegates elected six nominees to the U.S.P. Board of Trustees, including: Paul L. McLain, M.D., and Walter Modell, M.D., representing the medical sciences; Paul Parker, M.S., and Linwood Tice, D.Sc., representing the pharmaceutical sciences; and Leslie L. Eisenbrandt, Ph.D., and Fred Mahaffey, B.S., as members at large.

By constitutional amendment, the U.S.P. placed all Pharmacopeial activities on a five-year cycle rather than on a decennial basis; created the new post of Executive Director; provided for expanded informational services in connection with the U.S.P. drugs; and generally paved the way for more continuous representation and communication between the Convention officials and the Convention membership.

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Affiliation With The American Pharmaceutical Association

WHY?

Q. What is the MPhA-APhA Affiliation Proposal?

A. The formal proposal is in the form of an affiliation agreement to be executed by the Executive Officers of both associations. The agreement sets forth provisions for the mutual benefit of both associations.

Q. When will the agreement go into effect?

A. Immediately upon approval by members of the MPhA and the formal signing.

Q. How will individual MPhA members be affected by the agreement?

A. Present MPhA members will not be required to hold membership in the APhA.

Q. How will individual MPhA members benefit from the agreement?

A. Each member of the Maryland Pharmaceutical Association will benefit from a strengthened organization with increased ability to provide more services to its members. This will be possible because both associations will *share* the costs of providing many services each now provides separately. For example, it is possible for both associations to use the same computerized billing service for dues notices.

Q. Will APhA help the MPhA as an affiliated state association?

A. Yes, APhA has a number of services available to its affiliated state pharmaceutical associations. These include computerized joint dues billing service, combined membership recruitment effort, conferences for affiliated state association executives, special convention programs for affiliated state associations and *The Washington Spotlight* journal column.

Q. Why is the APhA in favor of affiliation?

A. Pharmacy's professional voice must be strong and must democratically represent all the nation's pharmacists, whether they own pharmacies or are professional associates in community or hospital practice or other phases of pharmacy. APhA realizes that the strength needed to guarantee pharmacy a bright future can only be achieved by encouraging strength at the local and state association levels. Affiliation is a means to achieve state and local strength.

Q. Can the affiliation agreement be severed?

A. Yes, by mutual consent of both parties, at any time.

Q. Have other state pharmaceutical associations affiliated with APhA?

A. Yes, 15 to date. These are California, Delaware, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, New Jersey, Pennsylvania, South Carolina, Texas, Virginia and Wisconsin. These associations represent more than 50% of the pharmacists in the United States.

Q. How will affiliation affect present Active MPhA members?

A. Since the spirit of affiliation lies in the philosophy of reciprocal membership, MPhA members will be encouraged to join the APhA if they are not already members. APhA will reciprocate this matter.

Q. Will affiliation affect Associate members?

A. No., membership categories such as honorary, life, associate, etc. of both Associations are not subject to reciprocal membership.

Q. Will affiliation affect MPhA's relationship with the N.A.R.D.?

A. Affiliation with the APhA will in no way conflict with the support given by the MPhA and its members to the N.A.R.D. Nor will it in any manner seek to prevent any member from continuing his support of the N.A.R.D. since it is recognized that the N.A.R.D. fills an important function as a national specialty organization representing the interest of drug store proprietors.

Q. How may organizations affiliated with APhA have voted to disaffiliate?

A. None.

Q. Does the N.A.R.D. have "affiliation"?

A. Yes, in a sense, but it is through local association—N.A.R.D. agreement, which completely bypasses the state association.

Q. Has affiliation with APhA hurt N.A.R.D. membership in an APhA affiliated State?

A. NO. Both the Executive Secretary of the N.A.R.D. and the 1969 President have been quoted in the negative on this point.

Q. Are APhA policy-makers community pharmacists?

A. 69% of the 268 accredited delegates to the APhA House of Delegates in 1968 represented practicing pharmacists. Both the Speaker and the Vice-Speaker are community pharmacists. Nine members of the 16 member Board of Trustees are practicing community pharmacists and a tenth member is the executive officer of a state pharmaceutical association. Every one of the candidates in the last Board of Trustees election was a community pharmacist who owns his own pharmacy.

Q. Has any affiliated state pharmaceutical association lost membership as the result of affiliation?

A. There is no proof of any such loss of membership. While one state pharmaceutical associations lost some members after affiliation, the gains more than offset the loss. In 1961, prior to affiliation the Michigan State Pharmaceutical Association membership stood at 1300. After affiliation in 1962 the membership increased to 2,263, to 2,551 in 1966 and over 2,700 in 1968. The MSPhA operating budget has increased from a 1962 level of $70,000 to $125,000 in 1966. Other affiliated state associations have enjoyed similar membership increases.

Q. Do the officials and officers of the Maryland Pharmaceutical Association favor affiliation?

A. Both the Executive Committee of the Association and the Affiliation Committee propose that the Maryland Pharmaceutical Association affiliate with APhA. Affiliation was endorsed by the membership at the Annual Convention on July 15, 1970 and will be presented for final approval at the Fall Regional Meeting, October 15, 1970.

Q. Under affiliation will the Association retain its autonomous structure?

A. Yes, MPhA will remain an autonomous state pharmaceutical association in every respect.

Q. How can I, as a member of MPhA support the proposal.

A. First, by being present at the Regional Meeting, Chestnut Ridge Country Club in suburban Baltimore. If you are unable to attend, by writing to the Chairman of the Affiliation Committee at the Associaion office, expressing your views.

Report of the Board of Pharmacy Study Committee

MELVIN J. SOLLOD, *Chairman*

The Board of Pharmacy Study Committee tried to evaluate the work of the Board and came up with specific recommendations to improve its functioning.

One of the basic problems in this evaluation was a lack of knowledge about the activities of the Board. To correct this, a member of our Association acts as an observer at Board meetings and reports back to the Maryland Pharmaceutical Association Executive Committee.

One of the criticisms of the Board was the perpetuation of the same individuals over many years. The committee recommends that after two terms the incumbents name cannot be brought out by the nominating committee. However, his name can be submitted from the floor for nomination.

To develop a more representative Board, the committee recommended that the Board membership be enlarged to seven people, area representatives be depleted and the salaries of Board members be fixed by the Secretary of the Department of Health and Mental Hygiene.

These changes were developed into a bill by the legislative committee and entered into the last legislative session. The bill would have been enacted except for a shortage of time, ending the legislative session.

It is very important for new regulations to the pharmacy law be enacted. The Maryland Pharmaceutical Association should be active in developing and promoting these regulations.

I wish to thank my committee for what I think was a very constructive approach to a difficult problem.

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Report of Resolutions Committee

Dr. William J. Kinnard, Jr., *Chairman*

To be acted on at Fall Regional Meeting October 15, 1970

Resolution No. 1

RESOLVED: that the Maryland Pharmaceutical Association respectfully urge Governor Marvin Mandel and the State Legislature to enact legislation prohibiting the sale or dispensing of all drugs except by a registered pharmacist.

Comment: Although the current laws prohibit sale or dispensing of certain drugs (prescription or "legend" drugs) except by a registered pharmacist, there are many other potentially hazardous therapeutic agents that can be purchased in any retail outlet including food stores, department stores and restaurants. These drugs can cause serious side effects although they do not require a prescription as they were "grandfathered" by federal legislation. The casual attitude of adults towards these drugs and the disrespect it creates among youth who misuse them for their psychic effects would be countered by the proposed legislation.

Resolution No. 2

RESOLVED: That the Maryland Pharmaceutical Association urge the United States Senators and Congressmen of this State to resist any attempt to reduce the appropriations of Health Professions Scholarships and Loans with special attention being given to prevent reallocation of funds within the appropriation away from pharmacy to any of the other health professions.

Comment: There are strong attempts being made to reduce pharmacy's allocation in the present congressional hearings. Support is limited now, and any further cut will seriously impair the program of the School of Pharmacy.

Resolution No. 3

RESOLVED: that the Maryland Pharmaceutical Association urge the adoption, through legislative action, of the following additional policy for the relicensure of pharmacists in the State of Maryland: The renewal of a pharmacist's license will, at 6 year intervals, be authorized by the State Board upon the pharmacist's satisfactory completion of an examination given by that Board or by presentation of proof of completion of suitable continuing education. The type and amount of continued education would be determined by a tripartite committee composed of representatives from the State Board of Pharmacy, the University of Maryland School of Pharmacy, and the Maryland Pharmaceutical Association.

Comment: The rapidly changing health care field and the great increase in new highly potent therapeutic agents require that the pharmacist maintain a constant education process to maintain his high level of professional competence. In the interest of public health, this can be partially assured through this change in license renewal procedures.

Resolution No. 4

RESOLVED: that the Maryland Pharmaceutical Association respectfully urge Governor Marvin Mandel to appoint a pharmacist to the Advisory Council of Drug Abuse as established by the 1969 "Comprehensive Drug Abuse Control and Rehabilitation Act."

Comment: The Act declares that it is imperative that a comprehensive program to combat the effects of drug abuse be developed and implemented through the combined and correlated efforts of individuals and governmental and private bodies. The Council is to advise the Governor and the Drug Abuse Authority in every aspect of drug abuse including education and prevention.

Resolution No. 5

RESOLVED: that the Maryland Pharmaceutical Association respectfully urge Governor Marvin Mandel to appoint a pharmacist to the Board of Review of the Department of Health and Mental Hygiene as established by the 1969 "Department of Health Act."

Comment: The Act creating "The Department of Health and Mental Hygiene as a principal department of the State Government with a Secretary of Health and Mental Hygiene," abolished the State Board of Health and Mental Hygiene, on which a pharmacist traditionally served.

As the advisory and appeals body to the departmental Secretary who is responsible for the operations, policies and promulgation of rules and regulations concerning all health activities in the State, the profession of pharmacy must be represented as a vital component of the delivery of health services.

Resolution No. 6

RESOLVED: that a comprehensive review of all State laws pertaining to the profession of pharmacy and drugs be undertaken under the aegis of the Maryland Pharmaceutical Association with the specific view of the Association sponsoring legislation that may be deemed necessary or appropriate for the protection of the public health and the profession.

Comment: The rapidly changing conditions in pharmacy practice and in the delivery of health services require assurance that the necessary legal mandates are present to meet current situations and those that prudent analysis indicate for the future. In particular, the areas of institutional pharmacy practice (hospitals, nursing homes, extended care facilities, clinics, etc.), and the use of supportive personnel in pharmacies should be investigated.

Resolution No. 7

RESOLVED: that the Maryland Pharmaceutical Association form a committee to examine the sale of potential health hazards in community pharmacies.

Comment: In view of the accumulating evidence that the use of certain products may be injurious to health, it is recommended that the membership evaluate the accumulated scientific data with the possible outcome that it be recommended that certain proudcts would be removed from sale in community pharmacies.

Resolution No. 8

RESOLVED: that the Maryland Pharmaceutical Association condemn the illicit distribution of legend drugs in sample form or otherwise, urge that all manufacturers' professional representatives be licensed by the State Board of Pharmacy in order to exercise control over the distribution of legend drug samples by professional representatives, and that a copy of this resolution be forwarded to the Pharmaceutical Manufacturers' Association, to the Food and Drug Administration and the Maryland Board of Pharmacy.

Comment: A serious health hazard is created when legend drugs, including samples, become available to the public without professional supervision, and the uncontrolled and indiscriminate distribution of samples of such drugs increases such hazard.

Resolution No. 9

RESOLVED: that the Maryland Pharmaceutical Association commends the Student Committee on Drug Abuse Education and pledges to continue to support its program.

Comment: The Student Committee on Drug Abuse Education has contributed effectively to better understanding by youth and adults of this great social and medical problem as well as to the enhancement of the image of pharmacy as a public health oriented profession.

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Toward Unity and Strength In Pharmacy—APhA and The State Associations

by William R. Whitten,
President of the American Pharmaceutical Association

Condensed from presentation at the 88th Annual Meeting of the Maryland Pharmaceutical Association, July 15, 1970, Shelburne Hotel, Atlantic City, New Jersey.

It is a pleasure to be with you this morning and to bring you the official greetings of your national professional society upon your 88th annual convention.

As I drove from Washington, D.C. to Baltimore last month to serve as Master of Ceremonies for the awards banquet of the National Science Fair program, I was reminded of the close ties the American Pharmaceutical Association has with the city of Baltimore and the state of Maryland. The Association owes much to the energies of love and devotion which Marylanders have lent to the development of the Association during its long history. As a matter of fact, as I reviewed our list of past officers recently, I learned that since 1856, there have been nine APhA Presidents from Maryland, and a host of other officers as well as other Marylanders, who have served in appointive and staff positions.

The name of H. A. B. Dunning stands out as one of those who contributed much to the Association, both financially as well as through service as President (1929-30) and as Chairman of the Building Fund Committee for the original APhA Headquarters Building which was dedicated in 1934. Other names which stand out as individuals who rendered outstanding service both to the Maryland Association and the APhA include Dr. Robert L. Swain, (APhA President, 1933), A. G. DuMez (APhA President, 1939-40), and E. F. Kelly, (APhA Secretary, 1925-1944). Of course, long time APhA staff member, Dr. Samuel Goldstein, of Baltimore, rendered yoeman service to the Association. Pharmacy education; and other pharmacy associations, including our national affiliates, ACA and ASHP, have also benefited from the professional leadership of Maryland pharmacists.

The results of the combined efforts of all of the individuals I have just referred to have been important to the development of the APhA over the years. But, just as significant, is the fact that your current officers have taken steps to insure that Maryland pharmacists and the Maryland Pharmaceutical Association will continue to have a leading role in the affairs of the American Pharmaceutical Association in the years ahead. I refer, of course, to the appointment by President Kerpelman of an affiliation study committee, and the efforts of your Executive Secretary, Nathan Gruz, and of your Executive Committee to see that the important committee recommendations of this are carried out, including giving the members of your Association the opportunity to make the ultimate determination regarding the affiliation of the Maryland Pharmaceutical Association with the American Pharmaceutical Association. I can truly say that I don't think that a more important issue for the future of pharmacy in Maryland and throughout the Nation could be submitted to the membership than this question.

To date, fifteen states have voted to affiliate with APhA. It now begins to appear that at long last pharmacy will exhibit the kind of maturity which it will need in order to survive as a health profession in the decade ahead. By providing a unified organizational structure for the profession through affiliation, pharmacists will have created a mechanism which will make it possible for pharmacy to influence the role which health care planners in government and in the private sector create for pharmacy under the Universal National Health Insurance Plan and other third-party payment programs which will be shaping the health care system before this decade is over. In my mind, this is the most important challenge facing pharmacy today. We must gear up to meet his challenge, and by affiliating with the APhA, the Maryland Pharmaceutical Association will have taken an important step in preparing for the challenges of the 70's.

How can affiliation assist your association as well as help the APhA meet the expectations of our members in this challenging decade? The answer to that question is multi-faceted, and in order to obtain a complete answer, your affiliation study committee has spent many hours investigating every aspect of what can be expected to be gained from the relationship which will result when your Association is affiliated with the American Pharmaceutical Association. However, let me mention some of the areas which benefit from affiliation.

First of all, communication between your state association and APhA is facilitated as a result of affiliation. One way in which communication is enhanced is through conferences at APhA Headquarters of the Executive officers of the Affiliated state associations. Just last week, the executives of the affiliated state associations met in Washington for a day and a half conference, where they received up to the minute briefings on APhA programs and activities, including status reports on federal legislative and regulatory matters of vital concern to their state association members. By being fully informed on the issues affecting their associations, as well as APhA, these state executives are in a better position to serve the interests of their respective associations as well as to lend their support to the implementation of the programs and policies of the APhA, which incidentally delegates from their associations in the APhA House of Delegates helped form.

As a pharmacist from Texas, which enjoys one of the largest state delegations in the APhA House of Delegates, I am firmly convinced that the APhA has benefited immensely from the advice and counsel provided by the delegates to the House as a result of the increased participation in the policy making function by the delegates in the House from affiliated state associations. Of course, when Maryland becomes an affiliated state, you will be entitled to an increase in the size of your delegation, and I can promise you that as a result of the active participation of these delegates that both the APhA House and the Maryland Pharmaceutical Association will experience a renewed activism and spirit which will immeasurably benefit both associations.

Communication between APhA and the state associations is further enhanced as a result of affiliation, in addition to the ways which I have just mentioned, by informative mailings sent to the officers of the Affiliated state associations, through special convention programs arranged by the Academy of General Practice of Pharmacy for affiliated state associations, and through staff liaison.

Affiliation also can be important to a state association in a dollars and cents way. By combining administrative functions, such as membership records maintenance, dues billing and collection, and related functions, significant savings of funds and staff effort can be realized. Inflation affects association budgets as much as any other segment of society. It is more important than ever before to be able to conserve funds and to make our staff efforts more productive.

Membership promotion is the keystone of affiliation, and through jointly planned and financed membership promotional efforts, affiliation offers the potential for overcoming pharmacy's biggest handicap in achieving professional maturity.

I had occasion at the AMA House of Delegates Reference Committee to explain why the APhA House earlier this year voted to seek the repeal of the various state antisubstitution laws. While the atitude of the physicians present did not surprise me, they made it clear that they are not willing to relinquish any aspect of their self-acclaimed perogatives to other members of the health team. Well aware of the fact that only one out of three of the pharmacists of this country belong to their national professional society, the physicians used this fact to argue that pharmacy cannot effectively exercise self-discipline, and, therefore, it is necessary to continue to prevent pharmacists from exercising their professional judgment by maintaining the antisubstitution laws on the books. To quote one of the physicians who was vocal on this opinion, pharmacists should be given greater opportunities to exercise their drug knowledge, "but still and always under the control and direction of the physician."

In the face of all of the evidence that there is a professional manpower shortage and a need for physicians to relinquish some of their functions to other qualified members of the health team, AMA is failing to recognize that pharmacists are a readily available source of qualified practitioners who are eager to assume a larger role in the delivery of health care to the public. Instead of talking about physician perogatives, the AMA should actively be encouraging pharmacists to exercise more professional judgment by selecting the drug product after the physician has decided which drug the patient needs. As I see it, the AMA is the irresponsible group in this instance.

Whatever position you as an individual pharmacist, or your association, might take on the question of selection of the drug product by the pharmacist, I would urge you not to take an impulsive action on the question, either for or against, but to form your own opinion only after careful consideration of all of the facts involved.

Legislative matters have always received considerable attention by the APhA. More than ever before, our lives, as citizens and as pharmacists, are affected by actions of the Congress. Evidence of this is the fact that in the past few weeks, representatives of the American Pharmaceutical Association have had the occasion to appear before Congressional committees no less than five times. We have testified on such important matters as Senator Hart's bill, which would prohibit physician ownership of pharmacies and drug repackaging firms, as well as physician dispensing; on Medicare and Medicaid problems experienced by pharmacists; and on financial aid for pharmacy students. We offered the Association's comments on drug labeling measures and offered suggestions which would help to eliminate kickbacks in federal programs involving pharmaceutical services to nursing homes and small hospitals.

Later this month, we will again testify on the Controlled Dangerous Substances Bill and seek to have the bill amended to make it clear that pharmacists will not be required to maintain a perpetual inventory of stimulant and depressant drugs. Such action will avoid what otherwise would require herculean and, in our opinion, unproductive effort by pharmacists. Keeping perpetual inventory records would needlessly raise the cost of providing pharmaceutical services to the public without resultant elimination of the drug abuse problem the bill seeks to solve.

One of the important recent steps taken by the APhA to see to it that pharmacy's interests are safeguarded as pre-payment programs for pharmaceutical services develop was the establishment of the National Pharmacy Insurance Council. I'm pleased to be able to report to you that the NPIC is fully activated and is functioning with full time staff to implement its objectives. Pharmacist-Attorney Ralph Engel, a native of your own state, has been named NPIC Director, and, along with the Board of Governors, and committees of delegates, is working to make the NPIC the influential organization it was intended to be. Your association's delegate to NPIC, Mr. Donald Fedder, will be receiving periodic reports from the NPIC of policy statements developed for the consideration of the delegates. Such statements will provide guidance for the profession and the health insurance industry on important matters such as service benefits, reimbursement methods and administrative processes. Real progress has already been made toward the development of a universal claim form which should provide needed relief to pharmacists in the administrative problems presently connected with many of the present third-party programs.

As the president of your national professional society, I want to relate to you the concern of the APhA Board of Trustees for the needs of salaried pharmacists. I know from personal experience that associations can have an effective role in employee-employer relations, particularly in such non-wage matters as working conditions.

Several state associations have met their responsibilities in this area by forming employee-employer relations commissions, and through the development of employment guidelines and by conducting state-wide salary, fringe benefit and working conditions surveys. This kind of information is necessary in order that individual pharmacists have a basis on which they can personally reach equitable agreements with their employers regarding the terms and conditions of their employment. The alternative to providing this kind of assistance to our members is, I'm afraid, collective bargaining through labor organizations. As Professor Charles M. Rehmus of the University of Michigan has stated, "For groups of professionals who have not yet embraced the union model, alternatives still remain open. Which of the alternatives they will embrace depends, I think, not so much upon their fundamental ideologies, as upon the choices that their employers leave open to them."

(*Continued on page* 28)

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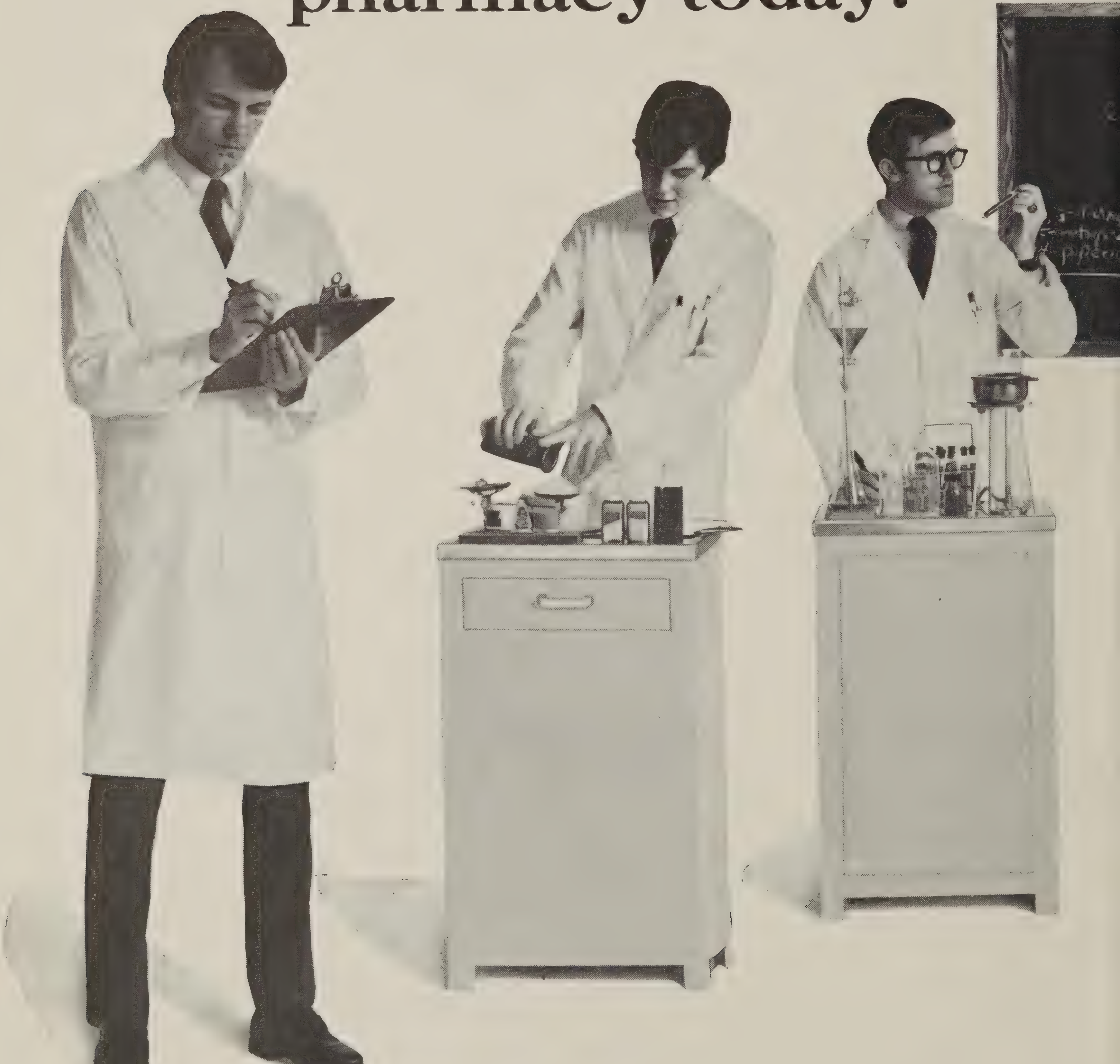

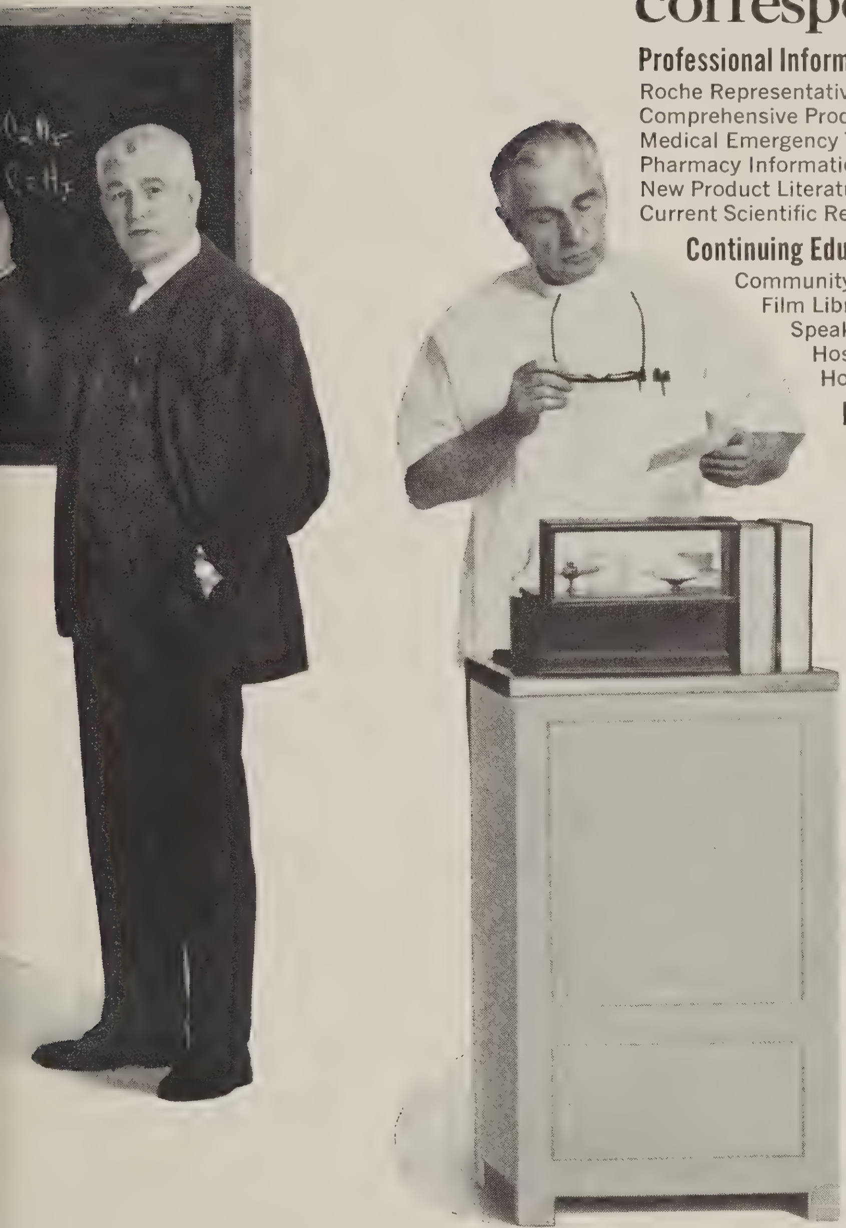

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- Nursing Home Information Services
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Aware of pharmacy's changing profile, Roche offers a wide range of supportive and informational services designed to meet individual professional needs.

Conceived and implemented by pharmacists for pharmacists, recipients, as illustrated here, may range from pharmacy student, educator and researcher to community and hospital practitioner.

These services and programs serve the pharmacist's ever-expanding day-to-day relationships and his broader role in health-care services for the community and hospital. In this commitment, Roche strives for new aids and systems to enhance pharmacy's position... and help stimulate high professional interest in the new pharmacy generation.

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Code of Ethics

Adopted By American Pharmaceutical Association
August 1969

Adopted By The Maryland Pharmaceutical Association
Executive Committee June 11, 1970

PREAMBLE

These principles of professional conduct for pharmacists are established to guide the pharmacist in his relationship with patients, fellow practitioners, other health professionals and the public.

SECTION 1

A pharmacist should hold the health and safety of patients to be of first consideration; he should render to each patient the full measure of his ability as an essential health practitioner.

SECTION 2

A Pharmacist should never knowlingly condone the dispensing, promoting or distributing of drugs or medical devices, or assist therein, which are not of good quality, which do not meet standards required by law or which lack therapeutic value for the patient.

SECTION 3

A pharmacist should always strive to perfect and enlarge his professional knowledge. He should utilize and make available this knowledge as may be required in accordance with his best professional judgment.

SECTION 4

A pharmacist has the duty to observe the law, to uphold the dignity and honor of the profession, and to accept its ethical principles. He should not engage in any activity that will bring discredit to the profession and should expose, without fear or favor, illegal or unethical conduct in the profession.

SECTION 5

A pharmacist should seek at all times only fair and reasonable remuneration for his services. He should never agree to, or participate in transactions with practitioners of other health professions or any other person under which fees are divided or which may cause financial or other exploitation in connection with the rendering of his professional services.

SECTION 6

A pharmacist should respect the confidential and personal nature of his professional records; except where the best interest of the patient requires or the law demands, he should not disclose such information to anyone without proper patient authorization.

SECTION 7

A pharmacist should not agree to practice under terms or conditions which tend to interfere with or impair the proper exercise of his professional judgment and skill, which tend to cause a deterioration of the quality of his service or which require him to consent to unethical conduct.

SECTION 8

A pharmacist should not solicit professional practice by means of advertising or by methods inconsistent with his opportunity to advance his professional reputation through service to patients and to society.

SECTION 9

A pharmacist should associate with organizations having for their objective the betterment of the profession of pharmacy; he should contribute of his time and funds to carry on the work of these organizations.

State of Maryland Department of Health and Mental Hygiene

NOTICE

FROM: John W. Morris
Chief, Division of Medical Services
SUBJECT: Flu Vaccinations in Nursing Homes
Maryland Medical Assistance Program

Following is the recommended policy concerning Flu vaccinations for nursing home patients covered by the Maryland Medical Assistance Program:

1. Flu vaccine may be ordered by the nursing home from a pharmacy. The vaccine should be ordered in ten dose, multiple dose vials. *A single* MS-6 Prescription Form signed by a physician should be written for a sufficient number of vials to treat those MAP patients requiring immunization. A list of patients receiving the vaccine and their current case numbers must be attached to the prescription.
2. Payment for the vaccine will be made to the pharmacy on the basis of acquisition cost plus $1.75 fee per 10 dose vial of vaccine. The pharmacy must indicate on the prescription the brand dispensed. The MS-6 must have the list of patients attached when it is sent by the pharmacist to the State for payment.
3. No payment will be made for syringes.
4. The vaccine may be administered at the direction of either the principal physician or the patient's attending physician. No special visit should be made by the physician for the purpose of immunizations alone. Vaccines should be administered during a routine visit for which the usual fee will be allowed.
5. All other systems for providing flu vaccine to MAP nursing home patients should be preauthorized by this office.

Administrators are requested to inform all physicians and the pharmacy servicing patients in the nursing home of the above procedures.

Questions concerning this letter my be directed to your local Health Department or you may call this office at 383-3010, extension 8871.

Advertisers Distributed 17.5 Billion Coupons in 1969, Nielsen Reports

Advertisers distributed 17.5 billion coupons to promote food and drug products in 1969, it was estimated by A. C. Nielsen Company.

This represented an increase of about one billion coupons over the preceding year, according to Nielsen Clearing House, which processes redeemed coupons for manufacturers and retailers.

Nielsen said coupons are used to attain a variety of marketing goals. Primary uses include interesting consumers in a new product, meeting competitive promotions, increasing advertising effectiveness, and obtaining wider product distribution.

SK&F announces the first Benzedrex® deal in over a decade!

FOR TEMPORARY RELIEF OF NASAL CONGESTION IN COLDS AND HAY FEVER WORKS IN SECONDS
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3 free with 33 plus $1.00 in cash display allowance

The Unstuffer™ Deal

Your cost	$19.47
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Your profit	$13.57

(includes $1.00 for display)

*Suggested retail price, $ .89 each—Deal expires October 31, 1970, or when supplies are exhausted.

A full 42.5% Profit

**stock up now—
display and recommend
The Unstuffer,™
Benzedrex® Inhaler**

Smith Kline & French Labs., Phila., Pa. 19101

Toward Unity and Strength

(Continued from page 23)

As was announced at our Annual Meeting, a new mechanism has been developed which enables the Association to assist both employed and self-employed pharmacists in obtaining a comprehensive insurance and retirement package at most favorable group rates. The formation of our Pharmacists Insurance Trust has been completed. PIT is a separate, incorporated activity of the Association with its own Board of Trustees who are directly responsible for this administrative activity. We have appointed our General Counsel and Comptroller and three pharmacists as Trustees. Two of the three pharmacist Trustees are young, employed practitioners. Their selection was intentional.

In a few weeks, a special mailing will be sent to the membership which will include application forms and the specific rate structure for each available policy.

Historically, fringe benefit programs—especially retirement features—have been used to discourage employee mobility. The plans offered through the Pharmacists Trust will be portable. Employers should offer pharmacists a full fringe benefit package with prompt vesting of the retirement feature. An enlightened policy on this matter will indicate to the employed practitioner that his status as a professional is both recognized and appreciated. Similarly, employed pharmacists should recognize the cost of the fringe benefit package to the employer and the tax advantages to the employee.

As one who has to meet a weekly payroll, I know, just as many of you do, that for salaried pharmacists to be able to have economic security including fringe benefit programs, such as are now available through the Pharmacists Insurance Trust, that the future of the independent practice of pharmacy can not be taken for granted. A week ago Sunday, on the front page of the Business and Finance Section of the *New York Times,* there was an article entitled, "Corner Drug Store Fades." The facts and figures presented in this article pertaining to the relative growth in the number of, and the annual sales volume of, chain drug stores and the closings of independent corner pharmacies have been well known to pharmacists for several years. I need not remind you that the APhA cautioned pharmacists to be alert to this trend a decade ago. When we made these predictions, our views were considered very unpopular by the very people we were trying to alert.

More recently, we have been alerting pharmacists to give serious thought and attention to the developing national health insurance programs and the role that pharmacy will play in them. It is the position of your national professional society that, instead of opposing changes which are inevitable, pharmacists and their organizations should cooperate in developing opportunities for pharmacist participation in these programs.

Within the last two weeks, we have seen the release of two major studies, both of which point to the increased role that group practice will play in the health delivery system of the future. I refer to the release of the Task Force on Medicaid and Related Programs, chaired by Walter J. McNerney which reported on its year long study on what to do about the Medicaid program, and, secondly, by the announcement of the Reuther Committee of One Hundred proposal for a national Health Security Plan, which emphasizes incentives for group practice. In plain language, what these developments mean is that there are going to be more clinics and there will be pharmacies in these clinics. This is why it is essential that the Hart Bill become the law of the land to financially separate the professions of medicine and pharmacy and to guarantee an opportunity for pharmacists to practice in these clinics, other than as employees of physicians. It is essential that pharmacists have the opportunity to obtain space in these clinics at reasonable rates rather than to be forced to pay what in some cases has amounted to ransom.

I want to make myself clear that I believe that there still will be a needed role for free standing pharmacies in the community. But, as we have been urging you for years, pharmacists should be considering joining hands together to form their own group practices so that they can function efficiently and put together the necessary capital that is required today to expand their professional operations. The group practice mechanism offers pharmacists, who otherwise would not be able to do so, an opportunity to establish themselves as self-employed practitioners. As I observe in my travels across the nation, many of the new pharmacies merely represent a change in location. I do not see as many young pharmacists becoming established as in years past. Again, I believe that through the group practice mechanism, we can reopen an opportunity that needs to be present to guarantee a strong and viable profession.

In light of the developing changes in the financing of health care, as well as in the delivery of pharmaceutical services, I can frankly tell you that APhA is devoting considerable effort to make sure that pharmacists have the opportunity in the future to be more than employees of corporations, hospitals and physicians. This is a different objective than preserving the neighborhood drug store per se, It would be folly to think that we could stop the wheel of progress. As president of the American Pharmaceutical Association, I can assure that during my term of office, I plan to do everything that I can to see that pharmacy remains an important spoke of that wheel.

New Perspective on Aging

Federal rules against discrimination in employment now outlaw age as a determinant in hiring, just as they previously demolished barriers based on race and sex. How this will affect mandatory retirement plans is unclear; eventually some worker aged 65 who wants to stay on may satisfy a court that not retaining him is tantamount to refusal to hire—especially since his age is the ruling factor.

Whether or not this happens, old timers seem bound to become more evident on the business scene. Younger men and women may regard this as retrogressive, but history is filled with people who achieved greatly in what are now regarded as the "golden years." Cornelius Vanderbilt was 79 when he linked New York and Chicago by rail; at 80 he added over $100 million to his fortune. At 81, Benjamin Franklin was dean of the Constitutional Convention. Adolphe Thiers was 73 when he formed the first French Republic. Starting at age 64, John Quincy Adams, who had been President of the United States, served Massachusetts for 17 years in the House of Representatives. In his years between 60 and 83, William Gladstone served four times as Prime Minister of England. Verdi wrote "Falstaff" at 80.

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Drug Information Sources Catch up with Electronic Age

With the increased emphasis on drug information these past few years, many new services are becoming available to the practicing pharmacist which simplify the work involved in seeking particular information. Here is a brief description of some of the more recent services available or planned.

1—*EDUTAPE FOR PHARMACISTS*

TYPE Cassette tapes

DESCRIPTION Each series of tapes, ranging from 3 to 15 units, consists of a complete course. Tapes are designed for standard cassette player. Subjects include pharmacology, management, business law, drug interactions and several others.

COST Monthly—$7.90 per unit (60 minute cassette).

SOURCE Professional Education Associates, P.O. Box 434, Skokie, Illinois 60076.

2—*DIS* (*Drug Information Service*) (Proposed)

TYPE Microfilm

DESCRIPTION Subscribers would receive a microfilm reader-printer and a microfilm file which would be completely replaced every 2 months. Copies of information shown on screen could be made by subscribers. Information covered would be from all published medical and pharmaceutical journals.

COST Estimated at $800.00 per year.

SOURCE Westwood Medical Communications, 1627 Pontius Ave., Los Angeles, Calif. 90025.

3—VOICES 12/60

TYPE Cassette tapes

DESCRIPTION Monthly cassette tape communications program with particular emphasis on clinical and hospital pharmacy practice. Sources of material will include presentations at institutes, interviews and panel discussions.

COST $80.00 per year includes 12 cassette cartridges each 60 minutes in length. Optional RCA player/recorder available $45.00.

SOURCE The American Society of Hospital Pharmacists, 4630 Montgomery Avenue, Washington, D.C. 20014.

4—DPIF (Drug Products Information File)

TYPE Computer oriented

DESCRIPTION Drug product information based on a computer-processable, internationally standardized coding system.

COST Approx. $1600.00

SOURCE The American Society of Hospital Pharmacists, 4630 Montgomery Avenue, Washington, D.C. 20014

5—IPA (International Pharmaceutical Abstracts)

TYPE Biweekly abstract journal

DESCRIPTION An international abstract periodical devoted to all phases of the development and use of drugs and to professional practice.

COST $30.00 per year (24 issues) to pharmacists

SOURCE The American Society of Hospital Pharmacists, 4630 Montgomery Avenue, Washington, D.C. 20014

Note: IPA also available on magnetic tape, discs for use with computers or as computer printout and available on microfilm to bonafide subscribers of IPA.

SOURCE OF MICROFILM IPA Xerox-University Microfilms, 300 North Zeeb Road, Ann Arbor, Michigan 48106

COST (MICROFILMS) Vol. 1 (1964) $7.00
Vol. 2 to 4 (1965-67) $4.25
Vol. 5 (1968) $4.25

Spectro Industries Breaks Ground For $1,500,000 Distribution Center

DISTRIBUTION CENTER
DISTRICT WHOLESALE DRUG CORP.
A DIVISION OF
SPECTRO INDUSTRIES INC.
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Left to right on picture: David Weed—Jenkins Construction Company, Melvyn J. Estrin—Spectro Industries, Ben Mulitz—Vice President, District Wholesale Drug Corporation, Harrison Weymouth, Jr.—Executive Director, Prince George's County, Economic Development Committee; Francis J. Aluisi—Chairman, Prince George's County Board of County Commissioners; David I. Estrin—Chairman of the Board, Spectro Industries; Philip Levin—Executive Vice President, District Wholesale Drug Corporation, Stuart Werner—Architect, Werner & Associates.

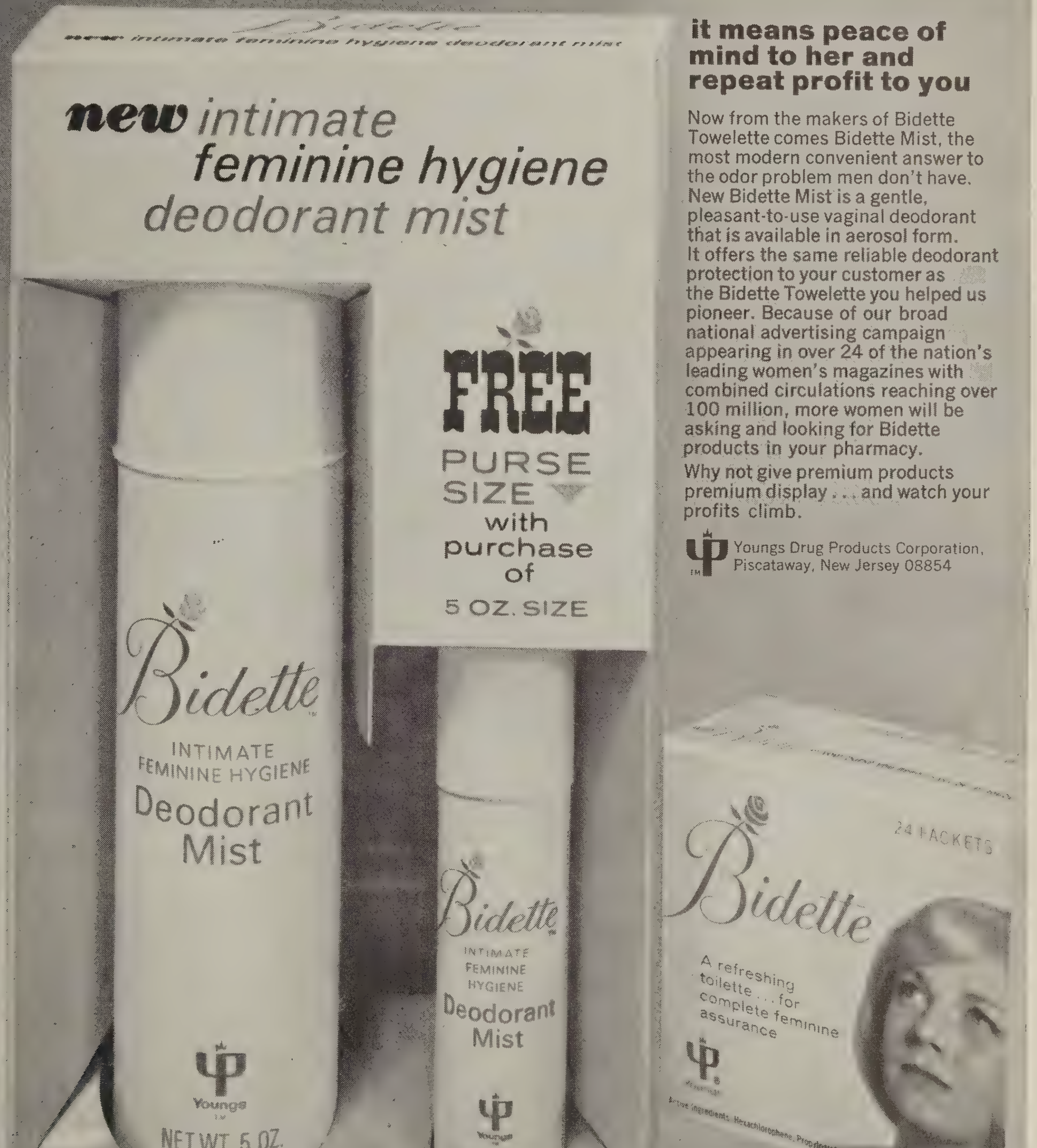
District Wholesale Drug Corporation, the Washington-based division of Spectro Industries, a nationwide company listed on the the American Stock Exchange, has begun construction on their new $1,500,000 distribution facility in the Ardwick-Ardmore Industrial Center in Prince George's County.

"The new 60,000 square foot office-warehouse-and-distribution center will provide District Wholesale Drug with all modern operation facilities" according to David I. Estrin, President of District and Chairman of the Board of Spectro Industries.

Designed by Werner & Associates of Washington, D.C. and being built by Jenkins Construction Company, completion is scheduled for January, 1971. Financing has been provided by Walker & Dunlop of Washington, D.C.

Loewy Drug Co., drug wholesaler in Baltimore, is also a division of Spectro Industries.

Sell her Bidette...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Bidette
A refreshing toilette . . . for complete feminine assurance
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Active ingredients: Hexachlorophene, Propylparaben, Alcohol

it means peace of mind to her and repeat profit to you

Now from the makers of Bidette Towelette comes Bidette Mist, the most modern convenient answer to the odor problem men don't have. New Bidette Mist is a gentle, pleasant-to-use vaginal deodorant that is available in aerosol form. It offers the same reliable deodorant protection to your customer as the Bidette Towelette you helped us pioneer. Because of our broad national advertising campaign appearing in over 24 of the nation's leading women's magazines with combined circulations reaching over 100 million, more women will be asking and looking for Bidette products in your pharmacy.

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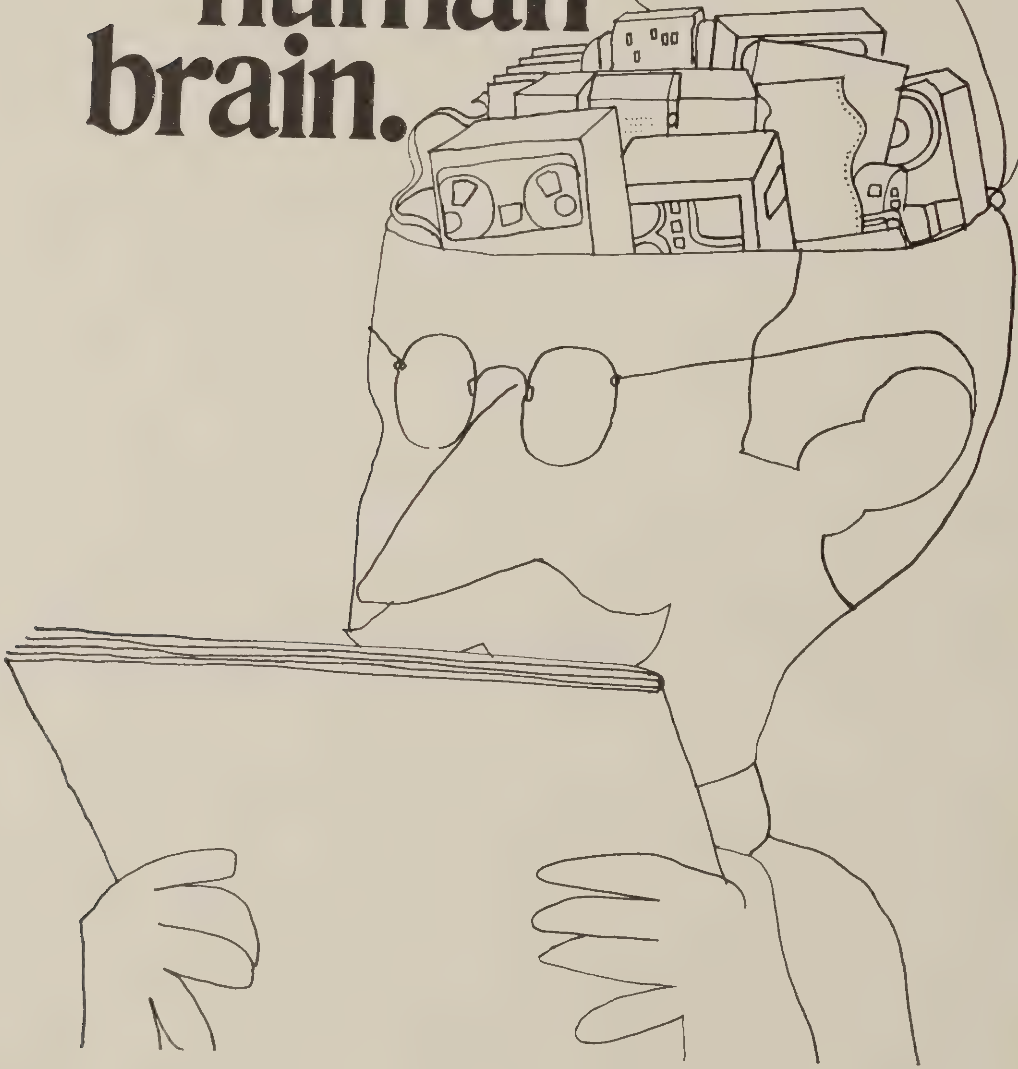

In an era of "information explosion," how do you "program" information to the human brain? Spoken language is far too slow. The average person speaks about 150 words per minute. Fast readers can read up to 1,500 words a minute—ten times the average rate for the spoken word. Perhaps this is why millions of people regularly purchase from pharmacies, magazines, paperbacks, comics and newspapers from insight and enjoyment.

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Thantis Lozenges have been found to be effective in soothing and relieving throat irritations. Merodicein, a topical antiseptic, clings to the treated areas and provides bacteriostatic action. Saligenin, a mild topical anesthetic, provides relief of soreness.

The Thantis Dispenser, containing foil-wrapped lozenges, provides aseptic dispensing of one or more lozenges.

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THANTIS® LOZENGES
DISPENSER
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ANTI-DANDRU
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In double-blind clinical studies, it was shown to have greater overall effectiveness than two leading anti-dandruff preparations.*

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*Tested were a zinc pyrithione preparation and a product containing hexachlorophene, sulfur and salicylic acid.

MARYLAND PHARMACEUTICAL ASSOCIATION
1882

the maryland pharmacist

Pharmacists Participate In Diabetes Detection Campaign

Photo by Paramount Photo Service

Pharmacists contribute to a vital community health service by taking part in the diabetes detection programs of the Maryland Diabetes Association. Irvin Kamenetz, (right), Baltimore County pharmacist, is shown demonstrating the use of urine sugar detection strips to an interested visitor at one of the Fifth Regiment Armory's booths manned by MPhA on the occasion of National Diabetes Week in 1969.

All pharmacists are urged to distribute Dreypak detection kits to their patrons throughout the year.

Volume 46 OCTOBER 1970 Number 10

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The Maryland Pharmacist

NATHAN I. GRUZ, *Editor*
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BALTIMORE, MARYLAND 21201

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Editorial . . .

CONTINUING EDUCATION—
Study or Perish!

Those pharmacists who have voluntarily engaged in life-time post graduate professional education have lived by the conviction that a pharmacist must continue to study or perish professionally. A professional engaged in a health vocation rapidly becomes obsolete unless he maintains a state of current knowledge and expertise.

Pharmacists have accomplished these goals by attending pharmaceutical and other meetings, conventions and seminars, by active participation in pharmaceutical association committees and programs, and by serving on councils of governmental and voluntary health agencies. Of course, self-study through regular reading books and journals, and correspondence courses are important educational vehicles.

The Maryland Pharmaceutical Association pioneered in promoting continuing education for pharmacists in Maryland through the establishment of the Swain Pharmacy Seminar and through speakers and panel presentations at regional meetings, conventions and various programs. The Maryland Society of Hospital Pharmacists sponsors an outstanding annual hospital pharmacy seminar as well as informative monthly meetings. The various local and national pharmaceutical associations are conducting educational programs.

The University of Maryland, School of Pharmacy which co-sponsored the Swain Pharmacy Seminar until this year, two years ago launched a program of continuing education in an attempt to go into greater depth on specific subjects, through evening sessions of up to eight weeks.

The subjects have been: "The Pharmacist's Responsibility in the Evaluation of Drug Quality" (co-sponsored by MPhA), "Institutional Pharmaceutical Services," "I. V. Additive Mixtures," "Drug Interactions," and currently "O-T-C: the Effective Use of Non-Prescription Drugs in the Ambulatory Patient."

These programs have drawn as many as 150 pharmacists for a course, but although gratifying as a beginning, this number represents far less than 10% of the practicing pharmacists in all facets of the profession.

The MPhA in 1968 was responsible for enacting into law a new definition of the "Practice of Pharmacy," which reads in part as follows:

> (a) "The "practice of pharmacy" is the practice that is concerned with the art and science of preparing, compounding and dispensing of drugs, medicines and devices used in the diagnosis, treatment, or prevention of disease, whether compounded or dispensed on the prescription of a medical practitioner, or otherwise legally dispensed or sold, and shall include the proper and safe storage and distribution of drugs, the maintenance of proper records, therefor, and *the responsibility of providing information, as required, concerning such drugs and medicines and their therapeutic values and uses in the treatment and prevention of disease.*" (Italics ours)—Section 250 (a), Article 43, Annotated Code of Maryland.

The responsibilities of the pharmacist in providing adequate, accurate, current information about drugs, their toxicity, potential hazards and possible interactions with other drugs and foods, can only be met by the *informed* pharmacist. This capability is essential in order to serve both patient, the prescriber and the commmunity. It is vital whether the drug is prescribed or over-the-counter. It is a prerequisite for service as advisors to government and private health agencies.

Through *organized* programs of continuing education, pharmacists are best able to be apprized of developments in drug therapy.

Two states—Florida and Kansas—now require satisfactory evidence of compliance with minimum standards of continuing education in order to qualify for reregistration. Now the Maryland Pharmaceutical Association, through resolution, has recommended the following:

> "RESOLVED: that the Maryland Pharmaceutical Association urge the adoption, through legislative action, of the following additional policy for the relicensure of pharmacists in the State of Maryland: The renewal of a pharmacist's license will, at 6 year intervals, be authorized by the State Board upon the pharmacist's satisfactory completion of an examination given by that Board or by presentation of proof of completion of suitable continuing education. The type and amount of continuing education would be determined by a tripartite committee composed of representatives from the State Board of Pharmacy, the University of Maryland, School of Pharmacy, and the Maryland Pharmaceutical Association.
>
> *Comment:* The rapidly changing health care field and the great increase in new highly potent therapeutic agents require that the pharmacist participate in continuing education programs to maintain his high level of professional competence. In the interest of public health, this can be partially assured through this change in license renewal procedures."

When a specific legislative proposal has been drawn up to implement the above resolution, it will be presented to the membership.

This is an opportunity for the profession of pharmacy in Maryland, through the leadership of the MPhA to demonstrate its commitment to the goal of assuring the highest standard of pharmaceutical services by its practitioners. The action will be a landmark for all the health professions everywhere.

PHARMACY CALENDAR

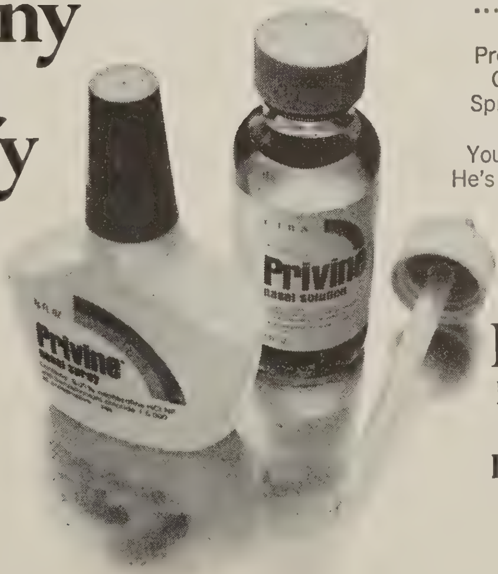
December 1—Remington Medal Dinner, Roosevelt Hotel, New York, N.Y.

December 5—TAMPA Meeting, Tail of the Fox, Timonium; 12:00 noon.

December 10— MSHP Meeting, Greater Baltimore Medical Center, Dr. Eugene Riley, Speaker.

January 31—Baltimore Metropolitan Pharmaceutical Association Annual Installation Banquet and Dance, Blue Crest North

Fast company for a stuffy nose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Secretary's Script . . .

DIABETES DETECTION WEEK

November 15-21, 1970

Pharmacists have played a significant role over the year in Diabetes Detection Week. In 1969 40,000 dreypaks were distributed by pharmacists with more than 2,000 returned for testing and 338 positives found. In addition, pharmacists helped man detection centers where they participated in the urine testing program.

Publicity through TV, radio and newspapers throughout the year will again direct the general public to their neighborhood community pharmacists to pick up a dreypak at no charge. Be prepared for calls for dreypaks. If you do not have any on hand, please order from MPhA at $3.00 per hundred, or the wholesaler who serves you.

There are thousands of undetected diabetes cases in Maryland. Providing dreypaks to your pharmacy patrons and assisting at detection centers, are important public service contributions to your community's health.

MPhA Needs Your Input

We need the opinions of our members on the issues in pharmacy and on programs we are planning or need. Some examples of areas of input we need from members:

1. Should pharmacists have greater responsibility in selecting the manufacturer of a drug he dispenses after selection of the chemical entity by the prescriber?
2. What Board of Pharmacy regulations are needed to implement laws or further public health?
3. What subjects should be considered for the Swain Pharmacy Seminar?
4. Should all or most medication be packaged in unit-dose packages for dispensing in hospital and community pharmacies?
5. Should the environment where the profession of pharmacy is practiced be completely separated from other areas with a separate entrance, independent of other operations?

We are looking forward to hearing from you about these and other issues in pharmacy.

Sincerely,

Nathan I. Gruz

A THOUGHT FOR THE DAY

You can't control the length of your life, but
you can control its width and depth.
You can't control the contour of your countenance, but
you can control its expression
You can't control the other fellow's opportunities, but
you can grasp your own.
You can't control the weather, but
you can control the atmosphere which surrounds you.
You can't control hard times or rainy days, but
you can work now to boost you through both.
So, why worry about things you can't control?
Get busy controlling things that depend on you!

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Phone 467-2780

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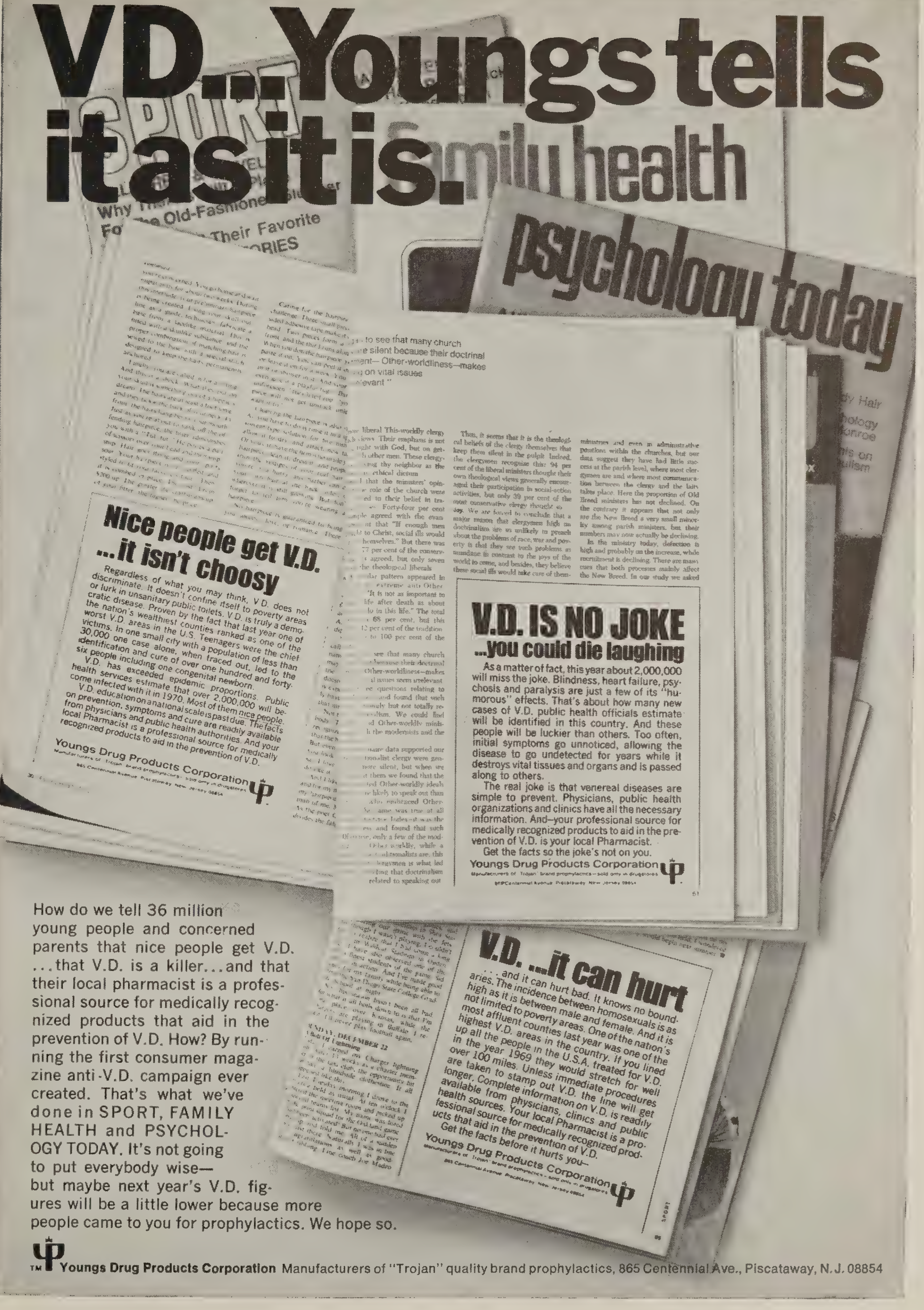

Nice people get V.D. ...it isn't choosy

Regardless of what you may think, V.D. does not discriminate. It doesn't confine itself to poverty areas or lurk in unsanitary public toilets. V.D. is truly a democratic disease. Proven by the fact that last year one of the nation's wealthiest counties ranked as one of the worst V.D. areas in the U.S. Teenagers were the chief victims. In one small city with a population of less than 30,000 one case alone, when traced out, led to the identification and cure of over one hundred and forty-six people including one congenital newborn.

V.D. has exceeded epidemic proportions. Public health services estimate that over 2,000,000 will become infected with it in 1970. Most of them nice people.

V.D. education on a national scale is past due. The facts on prevention, symptoms and cure are readily available from physicians and public health authorities. And your local Pharmacist is a professional source for medically recognized products to aid in the prevention of V.D.

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V.D. IS NO JOKE ...you could die laughing

As a matter of fact, this year about 2,000,000 will miss the joke. Blindness, heart failure, psychosis and paralysis are just a few of its "humorous" effects. That's about how many new cases of V.D. public health officials estimate will be identified in this country. And these people will be luckier than others. Too often, initial symptoms go unnoticed, allowing the disease to go undetected for years while it destroys vital tissues and organs and is passed along to others.

The real joke is that venereal diseases are simple to prevent. Physicians, public health organizations and clinics have all the necessary information. And–your professional source for medically recognized products to aid in the prevention of V.D. is your local Pharmacist.

Get the facts so the joke's not on you.

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V.D. ...it can hurt

. . . and it can hurt bad. It knows no boundaries. The incidence between homosexuals is as high as it is between male and female. And it is not limited to poverty areas. One of the nation's most affluent counties last year was one of the highest V.D. areas in the country. If you lined up all the people in the U.S.A. treated for V.D. in the year 1969 they would stretch for well over 100 miles. Unless immediate procedures are taken to stamp out V.D. the line will get longer. Complete information on V.D. is readily available from physicians, clinics and public health sources. Your local Pharmacist is a professional source for medically recognized products that aid in the prevention of V.D.

Get the facts before it hurts you–

Youngs Drug Products Corporation
Manufacturers of "Trojan" brand prophylactics—sold only in drugstores
865 Centennial Avenue Piscataway New Jersey 08854

How do we tell 36 million young people and concerned parents that nice people get V.D. . . . that V.D. is a killer. . . and that their local pharmacist is a professional source for medically recognized products that aid in the prevention of V.D. How? By running the first consumer magazine anti-V.D. campaign ever created. That's what we've done in SPORT, FAMILY HEALTH and PSYCHOLOGY TODAY. It's not going to put everybody wise—but maybe next year's V.D. figures will be a little lower because more people came to you for prophylactics. We hope so.

TM **Youngs Drug Products Corporation** Manufacturers of "Trojan" quality brand prophylactics, 865 Centennial Ave., Piscataway, N.J. 08854

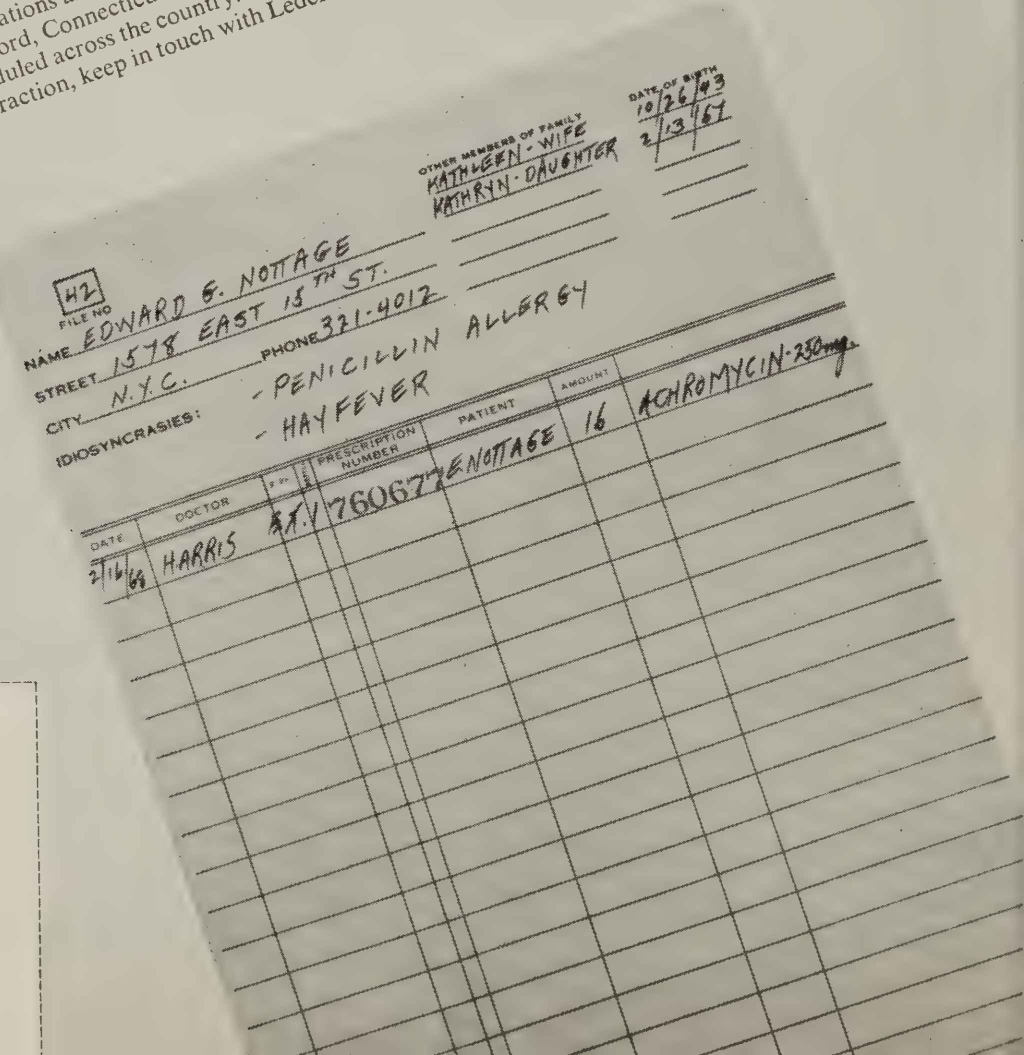
DRUG INTERACTION:

only you can know who is taking what with what!

As a pharmacist, you are the one most qualified to explain the intricacies of drug interaction not only to your customers—but to all your professional associates in the health care field. You alone have the background for this task.

But even a pharmacist may be at a loss to help his customers unless he has readily at hand the necessary information about which patients are taking which drugs. That's the reason why Lederle will mail to you at your request a sample of a commercially available Family Record Form typical of many in use today. (Simply use the coupon below.) Only with records like these is a pharmacist prepared to advise in individual problems of drug interaction.

Because Lederle is vitally interested in broadening knowledge about this important subject, we have inaugurated a program of Drug Interaction Symposia in collaboration with Schools of Pharmacy, Pharmaceutical Associations and Medical Societies. Two symposia have been held—in Hartford, Connecticut and Binghamton, New York—and others are being scheduled across the country. To keep in touch with developments in Drug Interaction, keep in touch with Lederle.



42
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NAME EDWARD G. NOTTAGE
STREET 1578 EAST 15TH ST.
CITY N.Y.C. PHONE 321-4012
IDIOSYNCRASIES: - PENICILLIN ALLERGY
- HAYFEVER

OTHER MEMBERS OF FAMILY	DATE OF BIRTH
KATHLEEN - WIFE	10/26/43
KATHRYN - DAUGHTER	2/13/67

DATE	DOCTOR	F.P.	[illegible]	PRESCRIPTION NUMBER	PATIENT	AMOUNT	
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Hospital Pharmacy Section

MSHP meeting of September 17, 1970

The September 17 meeting of the Maryland Society of Hospital Pharmacists was held at the Turner Auditorium of the Johns Hopkins Hospital. Dr. Paul K. Hanashiro, Director of the Shock-Trauma Unit of the University of Maryland Hospital, presented an interesting slide program entitled "The Pharmacologic Support of the Critically Ill Patient". The Squibb Out-going President's Award was presented to Samuel Lichter by William Davidson, Associate Director of Hospital Sales for E. R. Squibb.

Clarence Fortner, next years hospital pharmacy seminar chairman, reported that the 1971 seminar would be held again at the Carousel Motel the weekend of June 11. Room rates will remain the same as last year. Dr. Peter P. Lamy will be Program Chairman for the three day seminar.

A document is being drafted on a policy for after-hours pharmacy service by the Liaison Committee of the MSHP with the Maryland Nurses Association. Henry Derewicz and Samuel Lichter, members of the Liaison Committee with the Maryland Hospital Association, are working with this group in efforts to get the recently adopted *Suggested Guidelines for Pharmacy Service* implemented.

Kent Johnson, the new Chief of Pharmacy Services at the U.S. Public Health Service Hospital in Baltimore and William Zellmer, Assistant Editor of the American Journal of Hospital Pharmacy were introduced. Larry Hogue, pharmacy resident at the University Hospital, explained Kappa Psi's program for National Pharmacy Week. President Robert Snyder thanked E. R. Squibb for sponsoring the meeting and the meeting adjourned at 10:15 P.M.

Unit Dose Background Information

A "unit dose" is the specific amount of medication normally administered to a patient at one time.

Unit dose packaging is the enclosure of a unit of therapy in its own separate container—be it two tablets, one capsule, or an injectable syringe. Individual packages must be stamped with the proper generic name, trade name, strength, control number, and any pertinent special information such as an expiration date.

Principal advantages of the unit dose concept include: A lessening of medication errors through positive identification at all times; less chance of dose contamination; and greater economy as a result of convenience in handling and administering.

Unit dose packaging is the result of a logical evolutionary process. Not too many years ago, hospital pharmacists were overwhelmed by the endless needs of hundreds of patients. They would spend considerable time with mortar and pestle grinding chemicals, roots, herbs, and other pharmaceutical ingredients.

The advent of the pharmaceutical representative with his manufactured tablets, capsules, and bottled syrups rescued the pharmacist from his constant involvement in compounding prescriptions. These commercial medications, however, were usually in lots of up to 25 thousand making it necessary for the pharmacist to prepackage prescriptions for both floor stock use and individual patients.

For efficiency's sake, floor stock supplies were prepared for patients and sent to the wards where the nurse, in addition to her other responsibilities, often had to spend almost a third of her precious time reducing each medication to the prescribed dose. Medications taken from original containers would often lose their identity. The result was that a patient sometimes received the wrong drug or the wrong dose, and occasionally, fatal errors occurred.

Individually sealed and identified packages of medication began to appear in the mid 1960's, although this concept didn't grow until 1967 when the minimum wage law caused hospital wages and salaries to skyrocket. Today, labor and service costs make up the majority of all hospital expenses. More than half of America's pharmaceutical houses are packaging one or more of their products in unit doses to help save hospital labor costs.

Some hospitals have unit dose sub-pharmacies where supervised technicians prepare medication carts with separate patient drawers or compartments. Personnel brings these carts directly to the ward nurses, who give the doses. This gives the nurse more time for actual nursing duties. Thousand of man hours are saved by this procedure, and the cost of each administration of medicine is reduced by as much as two cents per dose, which over a year means thousands of dollars.

By 1971, it is expected that unit dose dispensing will be standard practice for 60 per cent of America's hospitals. By 1975, it is estimated by published studies that 90 per cent of all oral solids in hospitals (or more than 8 billion doses) will be individually packaged and identified. This is up from 10 per cent in 1968. At least 50 per cent of all oral liquids, injectables and topicals will also be individualized—up from 2 per cent.

CHANGE OF ADDRESS

When you move—

Please inform this office four weeks in advance to avoid undelivered issues.

"The Maryland Pharmacist" is not forwarded by the Post Office when you move.

To insure delivery of "The Maryland Pharmacist" and all mail, kindly notify the office when you plan to move and state the effective date.

Thank you for your cooperation.

Nathan I. Gruz, Editor
Maryland Pharmacist
650 West Lombard Street
Baltimore, Maryland 21201

University of Maryland School of Pharmacy

ANNUAL REPORT
to the
MARYLAND PHARMACEUTICAL ASSOCIATION

The following report outlines the activities of the School during the past year, but is not intended to encompass all school matters or to provide any depth in discussion of the activities.

Dean William J. Kinnard, Jr.

1. *GRADUATES*

Forty-eight students graduates from the School of Pharmacy with a Bachelor of Science degree on Friday, June 4, 1970. The graduation was held at the Civic Center in Baltimore, this being the first graduation held in Baltimore in over 40 years. Miss Carol Mae Paulick, Mrs. Dorothy Snoops Levi, Mr. David H. Jones, Mr. Robert L. West and Mr. John P. Becker graduated with High Honors, and Miss Sandra Lee Conklin graduated with Honors.

2. *ANTICIPATED ENROLLMENT, SEPTEMBER* 1970

Undergraduate:	Third Year	60
	Fourth Year	58
	Fifth Year	49
	Total	167

3. *FACULTY*

Promotions:

Dr. David A. Blake has been named Chairman of the Department of Pharmacology and Toxicology. Dr. Blake has served as Acting Chairman during the past year.

Department Name Changes:

The Department of Pharmaceutical Chemistry has been renamed the Department of Medicinal Chemistry, and the Department of Pharmacology has been renamed Department of Pharmacology and Toxicology. These new names reflect current trends in research and education in those particular fields.

New Faculty Appointments:

Assistant Professors:

Dr. Larry L. Augsburger, Pharmacy
Dr. David R. Brown, Pharmacology and Toxicology
Dr. Sharon K. Chapman, Pharmacology and Toxicology
Dr. H. Patrick Fletcher, Pharmacy and Pharmacology
Dr. Robert T. Louis-Ferdinand, Pharmacology and Toxicology
Dr. Karl-Heinz A. Rosler, Pharmacognosy

Instructors:

Mr. William R. Hodge, Pharmacognosy
Miss Helen O. Ross, Pharmacy
Mr. Henry G. Seidman, Pharmacy, and Coordinator of Continuing Education

Professor, part-time:

Dr. C. Jelleff Carr, Pharmacology and Toxicology

Assistant Professors, part-time:

Dr. Charles B. Barrett, Pharmacology and Toxicology
Dr. Joseph D. Jenci, Pharmacology and Toxicology

Departures from the Faculty:

Dr. Amin N. Jurf, Assistant Professor of Pharmacology and Toxicology
Dr. Ruth Millette, Assistant Professor of Pharmacy Administration.

Retirement:

Dr. Frank J. Slama, Professor of Pharmacognosy, will retire from the School of Pharmacy as of September 1, 1970. Dr. Slama, who has been with the University for 45 years, will be missed by all of his friends at the School. His untiring efforts to work with the students and faculty, and also with the Alumni Association can never be appreciated to the extent that we all wish possible.

Dean Emeritus:

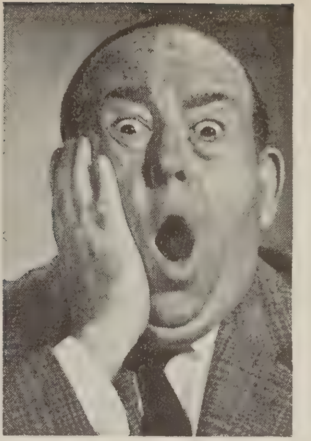
The Board of Regents of the University approved the recommendation of the Faculty of the School of Pharmacy that Dr. Noel E. Foss be named Dean Emeritus of the School of Pharmacy effective June 1, 1970. The Board gave its approval enthusiastically and asked for Dr. Elkins to express their appreciation for his service as a teacher, researcher and administrator.

Hospital Pharmacy Reorganization:

The University of Maryland Hospital and the School of Pharmacy have agreed to the joint operation of the Hospital Pharmacy Services in the University Hospital as of July 1, 1970. Dr. Peter P. Lamy, Director of Institutional Programs, will be in charge of the educational programs within the School and the service programs in the Hospital, coordinating both areas. Dr. H. Patrick Fletcher will coordinate the clinical pharmacy programs in the Hospital and Mr. Thomas E. Patrick will coordinate the distributive services within the Hospital, operating as Chief Pharmacist.

4. *RENOVATIONS*

All University departments are being moved out of the Dental-Pharmacy Building on South Greene Street so that renovations may be made to the entire building beginning in the fall of this year. The Department of Medicinal Chemistry is taking up interim quarters in the first floor of what was formerly the Dental Clinic in renovated laboratories until the completion of the Dental-Pharmacy Building. When the renovations have been concluded in approximately a year and a half, the School of Pharmacy will have four floors of that building devoted completely to Pharmacy operations, the first floor having new sound-proofed lecture rooms, the Department of Medicinal Chemistry having two complete floors, the Department of Pharmacognosy including Microbiology will have one complete floor.



You guys have got rocks in your head.

This Is Just One of the Things That a Group of Pharmacists Traveled 12,250 Miles to Tell Us.

Have you ever felt that *you* would like to fly to Philadelphia, march right into SK&F, and give us a piece of your mind? You know, maybe tell us how to run our business a little bit better?

Well, recently a group of pharmacists from all parts of the country spent two full days telling SK&F management what they like about our company. And what they *don't* like.

Some of the talk made us wince a bit . . . some was gratifying . . . and some reflected serious concerns about issues now dividing *your* profession.

They talked about the good and bad sides of a lot of matters. No holds were barred as the pharmacists and SK&F management waded into some of the many problems that concern you. As examples:

- **What about antisubstitution laws? Should they be repealed? Is the pharmacist really qualified to choose the patient's medication?**
- **Are rebates necessary after a manufacturer cuts prices?**
- **Are pharmacists in danger of losing their professional identity?**
- **Should manufacturers stop sampling MDs?**
- **Is pharmacy education writing off the corner drug store?**
- **Are drug formularies necessary under third-party payment programs?**

Because you couldn't attend this important Philadelphia conference and listen, *Pharmacy News*—SK&F's publication for pharmacists—is offering you a ringside seat at the meetings. *Pharmacy News* presents some of the highlights, the balanced conflicting viewpoints, in a condensed report on the sessions. What you read could reinforce your present stand—or even change your position—on a number of the major issues.

We think you might enjoy reading about what happens when a group of pharmacy and industry people sit down and tell it like it is. So, we would like to give you an "inside look" at SK&F's 8th Annual Pharmacy Advisory Council meeting by sending you a copy of the Fall 1970 edition of *Pharmacy News.* At no cost, of course. The magazine is coming off the presses now.

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5. *CONTINUING EDUCATION*

The School of Pharmacy under a Public Health Service grant sponsored a seminar on "Institutional Pharmacy Services" to nursing homes and extended care facilities during September 1969. This program brought together nursing home administrators, pharmacists and nurses to discuss the use of drugs and parapharmaceuticals in these facilities. Dr. Peter P. Lamy was Project Director for the seminar.

A five-week continuing education program entitled "Drug Interactions" was presented in the fall of 1969 at the University of Maryland Baltimore County Campus. This program was attended by 160 pharmacists and the program was conducted entirely by faculty of the School of Pharmacy. The program was repeated in condensed versions at the College Park Campus and at the Holiday Inn in Easton, Maryland. These two programs attracted a total of over 80 pharmacists.

A three-day seminar-workshop involving IV Admixture techniques was conducted in the school during February 1970. The program was directed and developed by Dr. Peter Lamy and Mr. Paul LeSage of the US Public Health Service Hospital in Baltimore. Representatives came from fifteen hospitals in Pennsylvania, Virginia and D.C. besides the state of Maryland. The program emphasized utilization of laminar flow hood operations in pharmacy services.

6. *OTHER SCHOOL ACTIVITIES*

The DuMez Lectureship was held on November 4, 1969 with Dr. George P. Hager, Dean of the School of Pharmacy, University of North Carolina as the speaker. His talk was entitled "Pharmacy, an Institution and a National Resource." Dr. Hager also met with the faculty and discussed future pharmacy programs in education and in practice. This lectureship has been supported by an endowment by Mrs. Andrew G. DuMez in memory of her late husband, and additional support this past year was provided by Dr. Bunting of the Noxell Company.

4. *SUPPORT OF SCHOOL ACTIVITIES*

Chain Stores:

The three major drug chains in the Baltimore area continue to support the School and its activities through generous grants. Giant Drug Stores, Inc., Peoples Drug Stores, Inc. and Read's Drug Stores provided grants of $2500, $1500 and $5000 respectively. This year was the 26th in a row that Read's has provided financial support to the School of Pharmacy.

Fellowships:

The Noxell Corporation of Baltimore has established a $5000 grant in the School of Pharmacy to provide a graduate fellowship in the area of cosmetic sciences. This fellowship will be under the direction of Dr. Ralph Shangraw.

The Dunning Foundation has increased the H. A. B. Dunning Fellowship award by authorizing an annual grant for the coming three years to provide a fellowship in the Department of Medicinal Chemistry.

The Merck Sharp & Dohme Pharmaceutical Company has provided a $5000 grant to the School of Pharmacy to provide for a research project in the Department of Pharmacy under the direction of Dr. Ralph Shangraw.

Medicaid Committee Report

NATHAN SCHWARTZ, *Chairman*

Recommendations:

1. The first recommendation of the committee was that the prescription form MS-6 be printed as a 3-part form; one part to be submitted to the State Health Department for payment, one part for filing in the regular prescription file, and a third copy as an Accounting Copy for the pharmacy so that when prescription is paid for, the third copy can be destroyed, and all unpaid prescriptions would be on this second file.

2. There was then a discussion of the method of compensation for over-the-counter drugs.

2A. The second recommendation is that all over-the-counter drugs whether in full or partial quantities and whether requiring an additional prescription label or not, should be compensated at a minimum total charge.

2B. It is further recommended that supplies such as bandages, rubbing alcohol, etc., be compensated at the regular OTC price as at present.

3. It was also recommended that Regulation 0403A read as follows: "Refills are authorized for legend drugs only. Legend drugs are those requiring a prescription by law."

4. The matter of what minimum amount should be set as requiring pre-authorization was thoroughly discussed.

5. It was decided that before making recommendations as to changing the present minimum of $10.00 minimum ingredient cost as the minimum for pre-authorization that a survey indicating the breakdown of prescription ingredient cost be made at the following levels: $10.01, $11.01, $12.01, $13.01, $14.01, $15.01.

6. The question of giving the state the authority to make minor changes on prices on prescriptions where errors had been made by the pharmacist were discussed.

7. It was recommended that there be inserted in Regulation 0301A: "Patient should be instructed by prescriber to have all prescriptions filled within 7 days." This should also be added to the present Regulation 0401.

8. The following was recommended to be presented as a resolution to MPhA: "If a code number is required to be placed on prescription labels, the national drug code number will be used."

9. After a thorough discussion of what should be the basis of cost under the Medicaid Program, it was decided that average wholesale price (AWP) should be used.

10. The matter of whether special direct prices to hospitals should involve a different cost base to be used by hospitals billing Medicaid program was discussed, as well as the matter of whether there should be a lower Medicaid presription fee for non-profit hospitals.

Kappa Psi News

The recently formed Maryland Graduate Chapter of Kappa Psi Pharmaceutical Fraternity Inc. would like to invite all members of Kappa Psi to attend their monthly meetings and to become active members. The chapter has 23 charter members and recently participated in promoting National Pharmacy Week by distributing literature and by taking part in a one hour radio program. The meetings are held in the homes of various members and are usually held on a Tuesday evening. Further information may be obtained by contacting Regent Larry Hogue at the School of Pharmacy.

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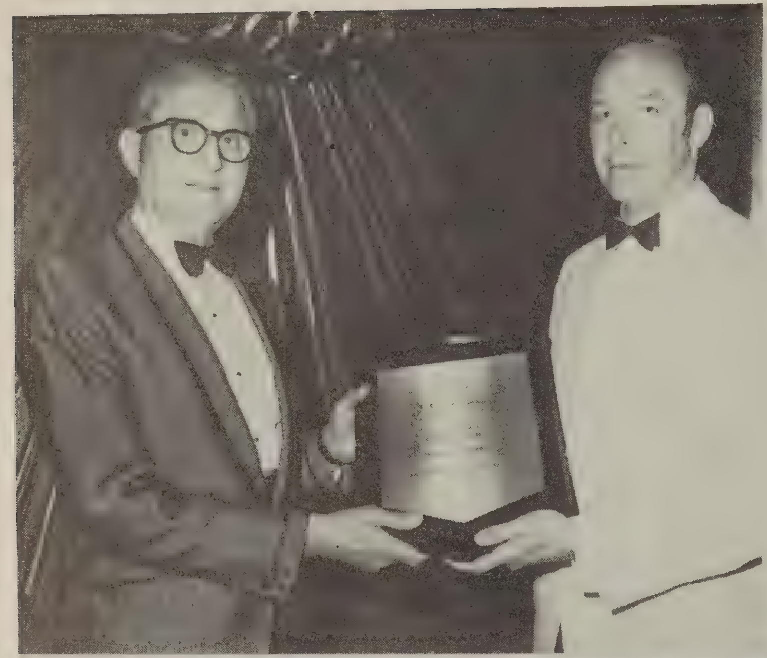
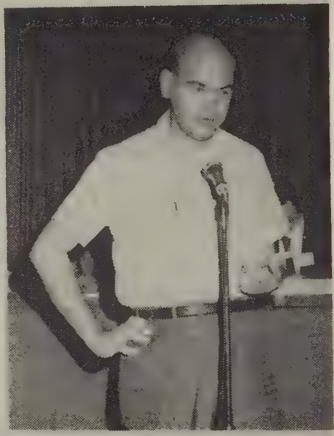
Convention Highlights





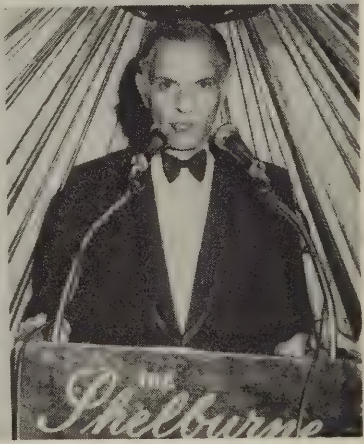


Photo by Paramount Photo Service

(Upper left) Outgoing President I. Earl Kerpelman receives Past President Award from President Donald O. Fedder.

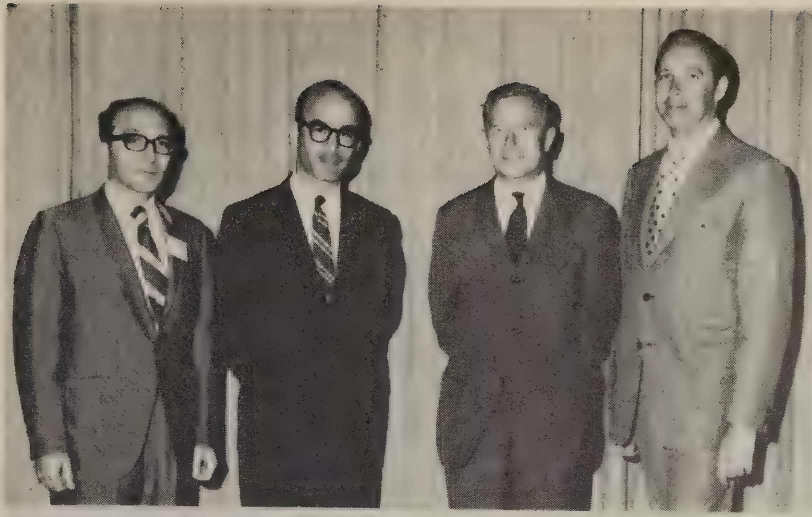
(Upper right) Darlene McMahon, President of University of Maryland APhA-MPhA Student Branch, presents student views.

(Center left) L. to R. Nathan I. Gruz, Executive Secretary; Dr. David M. French, Professor and Chairman of Department of Community Medicine, Boston University; Murray P. Ginsberg, Staff Pharmacist Good Samaritan Hospital; I. Earl Kerpelman, MPhA President 1969-70; Patrick H. Birmingham, Director of Department of Pharmacy and Medical Supply—Good Samaritan Hospital; and Donald O. Fedder, MPhA President-elect.

(Center right) Stuart L. Baltimore, Jr., Manager Pharmaceutical Services, Blue Cross.

(Lower left) L. to R. Secretary Gruz; Outgoing President Kerpelman; William R. Whitten, President APhA; and Convention Chairman Fedder.

(Lower right) Anthony G. Padussis, President BMPA, served as Banquet Toastmaster.



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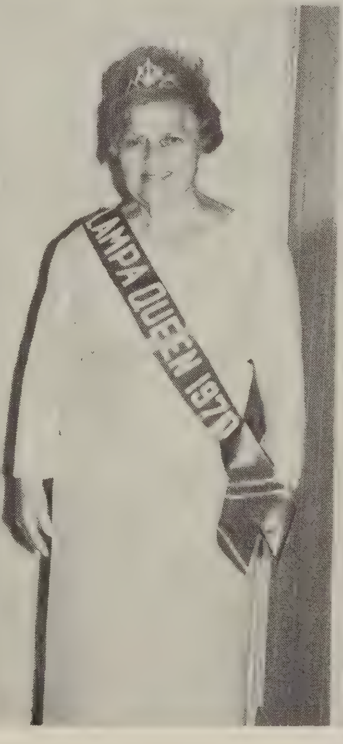
TAMPA QUEEN 1970

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(Upper left) L. to R. Nathan I. Gruz, Executive Secretary; Carl Roberts, Legal Counsel APhA; Dr. Matthew Tayback, Assistant Secretary of Health and Mental Hygiene; and Donald O. Fedder, President-elect MPhA 1970-71.

Fashion Models Tampa Night (Upper right) Mrs. Dominic (Mary) Vicino; (Center left) Mrs. Anthony (Arlene) Padussis; (Center right) Mrs. Richard (Anne) Crane.

(Center middle) TAMPA Secretary William A. Pokorney and President Nelson.

(Lower from left to right) TAMPA President William L. Nelson; LAMPA President Mrs. Louis (Dora) Rockman; LAMPA Queen 1970—Mrs. Rose Bloom, mother of members Herman, Leo and Morris, and grandmother of member Abriam Bloom; and Outgoing President of TAMPA, Frank Watkins.

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Report of Legislative Committee 1969-1970

Anthony G. Padussis, *Chairman*

The Legislative Committee meetings during the past year considered legislation that was needed as well as legislation proposed or introduced before legislative bodies.

A great deal of time was spent in Annapolis during the State legislative session by members of the Committee and particularly by our Executive Secretary, who was registered to represent the Maryland Pharmaceutical Association.

Secretary Gruz devoted most of his time during the session preparing testimony, following bills before Committees, contacting legislators, testifying before Committees, and, in fact, participated in the work of the important "Narcotics Committee."

As a result of tremendous expenditure of time and effort, here is just part of what was accomplished. Senate Bill 89 (Senator Harry Connolly), which would have required mandatory labelling of prescription ingredients on prescription labels was amended in the House of Delegates following our testimony. It now requires such labelling only if specified or requested by the prescriber.

Senate Bill 137 (Senator Julian Lapides) would have made it a felony for a pharmacist to dispense a prescription if transmitted to the pharmacist by other than the prescribing practitioner. As a result of our testimony and strong action, the bill was killed in the Committee headed by Senator Melvin Steinberg.

A flood of bills was introduced regarding drug abuse. A number of bills requiring a prescription for exempt narcotics was killed following our opposition. However, an important bill, Senate Bill 883, the "Controlled Dangerous Substances Act," was enacted. This law brings together all existing laws regarding narcotics, dangerous and prescription drugs into one overall revised law. This complex law was drafted under great pressure, within a few weeks, with the aid of a number of consultants, including Secretary Gruz, who received a commendation from the Chairman of the special committee, Senator George Snyder, for his important contributions to the committee's work.

Because of the haste of drafting and the dominating influence of police law enforcement people, and the Federal Bureau of Narcotics and Dangerous Drugs personnel, the law has many defects and was not completely acceptable to us. In spite of the efforts of scientifically and medically oriented representatives such as our own, the law requires certain controls, penalties, and other provisions which indicates a police approach to the problems of drug abuse. As a social and medical problem, the solution to drug abuse is much more complicated.

The law is so complex and unclear in parts that the State Department of Health is still awaiting clarification from the Attorney General on a number of points important to pharmacy and everyone else. Although the Act was effective July 1, 1970, the Division of Drug Control under Frank Balassone, indicates it may not be in a position to develop guidelines for many months.

One provision is of great importance to pharmacy. Maryland Pharmaceutical Association advocated that exempt narcotics be available for sale personally by the pharmacist and it was so enacted. The law requires that a special label be placed on "exempts" when sold, with the pharmacist's name, signature, registry number, date dispensed and purchaser's name.

Our legal counsel is working with our Secretary to review the entire act with the view of providing our members with a summary of the 31 page law and to the possible introduction of amendments to clarify and improve the law in the next session of the legislature.

We were also successful in defeating in committees a Fair Trade Repeal Bill and a bill to require a warning label on prescriptions for oral contraceptives.

An important bill of great length and complexity was a new State Food, Drug and Cosmetic Bill. Our Secretary worked with the Governor's staff on the bill and testified for the bill with amendments. Incorporated into the Bill, as a result, were certain protective clauses for pharmacists. We proposed that all non-prescription medication, as well as prescription drugs, require disclosure of all ingredients on their labels.

There was other legislation affecting medical care which we were concerned with, but I will close with one setback we suffered. We introduced a bill to enlarge the Board of Pharmacy from five to seven members, remove place of residency requirements and leave compensation to the Secretary of Health and Mental Hygiene. The bill was opposed by Senator Lapides, who tried to amend the bill to death. He succeeded in passing one amendment on the last day of the session and the Legislature adjourned before enactment of the law. This bill, in essentially the same form, will be reintroduced. As you know, we were also successful in getting approval for an increase in the Medicaid prescription fee to $1.75. This means $550,000.00 additional to the pharmacists of the State.

I want to express my thanks to my co-chairman, Bernard B. Lachman, and the other members of the Committee and Association who worked hard throughout the year to further the Association's Legislative Program. I also want to give proper recognition to our hard-working Executive Secretary, Nathan Gruz, who devoted so much of himself to the goals of the Maryland Pharmaceutical Association. He has won great respect and consideration from the Governor's office, the Budget Bureau, the Health Department and the legislators.

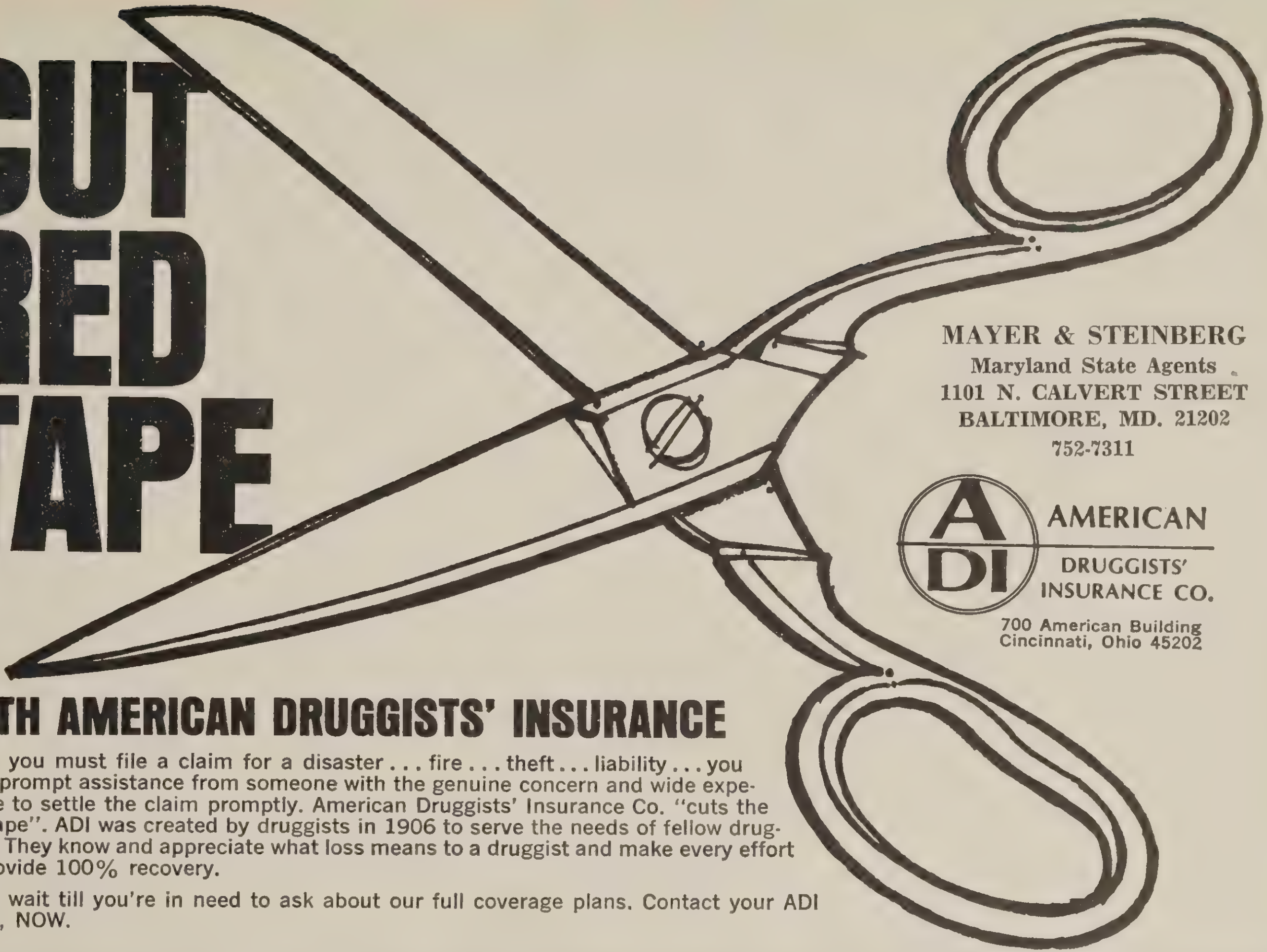
On the whole, I think we accomplished much. I believe in the coming years we will be in a better position to do even more.

Report of the School of Pharmacy Committee—1969-70

Melvin J. Sollod, *Chairman*

The School of Pharmacy Committee has continued to work with the Recruitment Committee of the School of Pharmacy. We have been active in representing pharmacy in career day programs in various high schools and a junior college. This fall, for the first time, Montgomery College will have a pharmacy career day, because of our efforts.

The Hospital Council of Maryland has helped formation of the The Maryland Hospital Research Foundation. This new group called a meeting last May of all the allied health groups to develop a unified recruitment program. Our organization will be represented in this group which has a far reaching potential in influencing young people into the various health fields.



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Report of the Public Relations Committee

CHARLES E. SPIGELMIRE, *Chairman*

Throughout the past year, your Public Relations Committee has worked hard, and unceasingly, with one guiding thought in mind and that is, pharmacy's most important relations are public relations.

Using every available means at their command, the members of your committee have waged an intelligent, aggressive, cooperative and educational campaign to make the public realize that pharmacy is a profession to be proud of and not just another business to ridicule.

We know that many pharmacies have abdicated their strongest, most favorable factors. Personality of the pharmacist, and atmosphere of the pharmacy are being allowed to disappear.

People still prefer to do health business with a man who proves his knowledge, interest, and capacity for being helpful in such matters. Pharmacies need to understand promotion and the development of traffic. The pharmacy needs a modern setting. It needs to get in touch with its customers. Your committee felt that pharmacy is like the game of tennis, in that the man who does not serve well, will usually lose in the end. We felt that the pharmacists of today should be correlated and integrated with an intelligent and broad public relations program which strives continuously to inform the public that the pharmacist is still their best neighbor.

We did our best to demonstrate that the community pharmacist could function as a cooperative and cohesive unit. Sunday after Sunday during the past year, our Association had the benefit of a fifteen minute radio broadcast over Station W.C.A.O. in Baltimore, from 10:30 to 10:45 P.M. Sunday evenings. While the broadcast emanates in Baltimore, it is intended for the entire State of Maryland. It might be interesting for you to know that we have completed just about 600 consecutive broadcasts on this station. The program is identified by the theme "Hi Neighbor," and, as usual dedicated to you, the public's "best neighbor." On these programs we try to discuss and explain every phase, every facet and every problem of pharmacy.

We explained that pharmacists are respected public servants. They should be. They labor competently and diligently to promote and to protect the nation's physical health. It is this valuable service and this service alone that justifies the perpetuation and the continued legal protection of our profession of pharmacy.

We told the public that you, the modern pharmacist, performs a front rank medical work. One that is essential to the well being of society. He fulfills a great human need. Long centuries of dependable service, based on abundant competence, sound moral character and demonstrated worth, have earned for pharmacists public trust, confidence and good will.

We showed that it is from the prescription department that the medication ordered by the physician becomes available to the patient. This department is truly the heart of the pharmacy. Here the pharmacist brings into play his basic professional training.

We brought home the fact that of all the truly American institutions, perhaps none is more familiar than our pharmacies. They are to be found on the busy corners of our cities. They form a part of every neighborhood or community, they occupy a high place in the esteem and preference of the customer.

Many times we have warned the people not to indulge in the seemingly innocent practice of consolidating their medications, such as putting aspirin, soda tablets and saccharin into one box. This might be dangerous. Not only for the owner, but for someone else who doesn't know why the label says one thing and the contents of the box indicates that this can't be so. We repeated over and over that by law and tradition the responsibility for compounding prescriptions rests with the pharmacist. It is an important responsibility to which your pharmacist must bring skill, a keen sense of accuracy, and a scientific knowledge of the composition, properties and uses of the drugs he handles.

For their cooperation, advice and assistance, I would like to thank Mr. Byron Millenson, Manager of Station W.C.A.O., Mr. Charles Purcell, Public Service Director and Mrs. Colleen Harting, Program Director of the Station. During 1969 your Public Relations Program was a most complete and comprehensive one. It told about pharmacy, the pharmacist and pharmaceutical practice. Your committee explored every phase of publicity available to bring to your association and pharmacy the recognition they so justly deserve. Your Public Relations Committee has always been most anxious to cooperate with any other committee requiring its assistance and advice. It has always been a pleasure to extend a helping hand to assist other Chairmen to attain success in their activities. During the past year your Public Relations Committee helped to make Diabetes Detection Week, Pharmacy Week, and Poison Prevention Week, outstanding endeavors.

Our work during the past year was not that of any one individual but rather the culmination of a cooperative effort of many, many wonderful people. It has had its headaches and heartaches but the magnificent spirit exhibited by this committee made the heavy burden seem light.

I want, particularly to commend our Executive Secretary Nathan Gruz. For her kindness and cooperation, I sincerely thank Mrs. Margaret Huber, Secretary to Mr. Gruz.

Pharmacy Changes . . .

The following are the pharmacy changes for the month of October:

New Pharmacies

Ingleside Pharmacy, Inc., Faye Maguire, President, 315 Ingleside Avenue, Baltimore, Maryland 21228.

No Longer Operating as Pharmacies

Adams Drug Store, Manuel K. Highkin, President, 1401 Edmondson Avenue, Baltimore, Maryland 21223.

Guilford Pharmacy, Inc., Norman Schenker, President, 2801 Guilford Avenue, Baltimore, Maryland 21218.

Change of Ownership, Address, Etc.

Stemmers Run Prescription Center, Manuel K. Highkin, President, 405 Stemmers Run Road, Essex, Maryland 21221.

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Swain Seminar and Continuing Education Committee Report

PAUL FREIMAN, *Chairman*

The 10th Annual Robert L. Swain Seminar was held this year for the second time at the Holiday Inn, Downtown. The theme this year was "The Pharmacist's Role in Controlling Drug Abuse." Ninety-three pharmacists were in attendance for this afternoon-evening seminar.

The 1970 Swain Seminar set for itself two objectives: the first was to provide a comprehensive overview of current knowledge on drug abuse problems and how the pharmacist may contribute to improving the situation, and second, to develop a cadre of pharmacists to serve as members of the Maryland Pharmaceutical Associaton Drug Abuse Speakers Bureau. Those in attendance hopefully will attest to the success of the first goal, and at this writing the committee is actively working toward the second.

Overall the 10th Annual Swain Seminar was both a financial and educational success. Through the generous contributions of Merck, Sharpe and Dohme; Eli Lilly; CIBA; Smith, Kline and French; and Warner-Chilcott drug companies we were able to obtain the finest of speakers and insure a base from which to work on future endeavors. My thanks must go to our excellent speakers; Dr. David A. Blake, Rev. Frederick Hanna, Dr. Emmett Davis, Dr. David Nurco, Mr. Richard Russo, Mr. Michael Luzuriaga and our evening speaker Dr. Helen Nowlis.

In conclusion I would be remiss if I did not once again thank our Executive Secretary, Mr. Nathan Gruz, for his outstanding work on insuring the success of the Seminar both in content and financially. His efforts in contacting the drug companies and in lining up our guest speakers was invaluable, and without his efforts and those of his staff, especially Mrs. Huber and Mrs. Gibson, the Seminar would not have been possible. I would also like to thank my committee, especially Co-Chairman June Shaw, for their efforts on behalf of the success of this Seminar.

Once again I would like to thank the Maryland Pharmaceutical Association for the privilege of serving as Chairman of the Annual Swain Seminar.

Report of Professional Relations Committee

IRVING KAMENETZ, *Chairman*

National Diabetes Week—Nov. 16 to Nov. 23, 1969

Your Chairman first started meetings with representatives of the Maryland Diabetic and American Diabetic Associations, on Friday, September 26, 1969, at North Charles General Hospital. The fee from pharmacists for the Dreypaks enabled us to insert a newspaper ad in the Sunpapers, listing the cooperating drug stores. In addition we had many radio, television and news releases mentioning the availability of the Dreypaks at neighborhood pharmacies. Your chairman appeared on Channel 2 on Saturday, November 15th on "Your Family Doctor" program, with Dr. Reed, Chairman of the Maryland Diabetes Association Diabetes Drive. On the program (the first time a pharmacist has appeared) I demonstrated a clinitest of urine for sugar, and also showed the Dreypak and explained the pharmacist's role in the care of the diabetic patient, and in the drive to find the hidden diabetic. I also appeared with Charles Spigelmire on the WCAO radio station program "Your Best Neighbor." In addition, we had pharmacists participating in all testing centers at the 5th Regiment, Glen Burnie, Towson and Dundalk Armories, usually evaluating urine samples. In a letter received from Dr. Reed we show the following results of our efforts:

> "We decided to make diabetes detection a year-round effort for the pharmacists, so this year we are urging the pharmacists to continue to display and distribute free Dreypaks. To back this up we have written to radio and T.V. stations to advise the public of the availability of the tests."

Poison Prevention Week

We cooperated with the publicity committee in getting many announcements under the heading "Your Neighborhood Pharmacist." Your chairman and other pharmacists spoke on the radio on the subject; President Kerpelman met with Governor Mandel on the issuing of a Proclamation. Banners were distributed to all drug stores in the State and many special windows were displayed. These efforts created great public awareness.

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Act of October 23, 1962; Section 4369, Title 39, United States Code)

1. Date of filing: September 23, 1970.

2. Title of Publication: MARYLAND PHARMACIST

3. Frequency of issue: Monthly

4. Location of known office of publication: 306 N. Gay Street, Baltimore, Maryland 21202

5. Location of the headquarters or general business offices of the publishers: 650 W. Lombard Street, Baltimore, Maryland 21201

6. Names and addresses of publisher, editor and managing editor:
Publisher: Maryland Pharmaceutical Association, 650 W. Lombard St., Baltimore, Md. 21201
Editor: Nathan I. Gruz, 650 W. Lombard Street, Baltimore, Md. 21201
Managing Editor: Nathan I. Gruz, 650 W. Lombard Street, Baltimore, Md. 21201

7. Owner (If owned by a corporation, its names and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.)
Maryland Pharmaceutical Association, 650 W. Lombard Street, Baltimore, Maryland 21201, (Non-Profit Corporation)

8. Known bondholders, mortgagees and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities: None

10. Extent and nature of circulation

A. Total No. Copies Printed	1450*	1450†
B. Paid Circulation		
1. Sales Through Dealers and Carriers, Street Vendors and Counter Sales	None	None
2. Mail Subscriptions	1250	1250
C. Total Paid Circulation	1250	1250
D. Free Distribution by Mail, Carrier or by Other Means	150	150
E. Total Distribution	1400	1375
F. Office Use, Left-Over, Unaccounted, Spoiled After Printing	50	75
G. Total	1450	1450

* Average No. Copies Each Issue During Preceding 12 months.

†Single Issue Nearest to Filing Date

I certify that the statements made by me above are correct and complete.

NATHAN I. GRUZ.

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L.A.M.P.A.

The Ladies Auxiliary of the Maryland Pharmaceutical Association

Since many of our members were unable to attend our annual Convention in Atlantic City, we thought it would be nice to tell you a little about what happened on Ladies Day, July 14, 1970.

After breakfast, we traveled by air conditioned bus to the House of Renault. There, after appropriate toasts and frivolity, we enjoyed a pre-luncheon drink of "Cold Duck." Staggering a bit—we toured the museums, manufacturing areas and wine cellars. The gift shop, our last stop, permitted our ladies to stock up for future "Happy Hours."

The Wading River Room at Smithville was the charming setting for our annual luncheon meeting. After soup, salad and a yummy dessert, we were ready for all the annual reports. Old business, new business and a round of applause, which followed the farewell speech of our outgoing president, Mary Schrader. Her two-year term saw our Constitution revised, our bank balance healthy and interesting programs: ranging from author to herbist, from art professor to interior decorator; plus two delightful bus trips.

Our new President, Dora Rockman, very graciously accepted her nomination and election, and introduced her Officers and Executive Board. Dora's long career in teaching, as well as her poise and chairman will add to the office of President. She is a charter founding member of LAMPA and she and her husband Lou have been loyal conventioneers for many years.

Business over, we drew the name of our Queen For A Day—and she was Mrs. Rose Bloom, mother of Herman Bloom, and we couldn't have been happier with the choice. She was crowned, given a ribbon streamer of her position, as well as a sterling scarf pin.

As we left the meeting, each lady was given a colorful plastic tote bag and a make-up mirror. Free at last, the ladies scattered to pick up items that can only be found at Smithville, like cranberry soap or wrought iron snow eagles. The bus returned to the Shelburne at about 3:45 p.m., just in time for a quick rehearsal for the "So What's New" Fashion Show that night.

Dinner over, the models gathered with their attic treasures. We had a peach satin ball gown over 100 years old; a dress from the Philippines made of vegetable fibers with a train and see-thru top; a brown Georgette that walked the boardwalk in 1925 and a cape from the trousseau of one of our officers. We had lots of elegant clothes from the 1945 to 1952 era and even a micro-mini worn by the daughter of a board member. Also, a "new" 1970 style midi, made by one of our members. The show closed with a walk down the runway of our "Queen For A Day" on the arm of Bill Pokorny, Secretary of TAMPA. Expert commentary was provided by Frank Watkins. At the finale, our LAMPA models threw real Black-Eyed Susans (our State flower) to the audience. Oh yes, they played bingo before and after the show. A comment heard after the show: "More, they should have had more." Seems like they liked it.

A bit of name dropping and credits:

L.A.M.P.A. Officers for 1970-71

Dora Rockman, President; Sadie Wagner, Membership Treasurer; Dorothy Austin, Treasurer; Mary DiGristine, Recording Secretary and Ann Crane, Communication Secretary.

Executive Board

Mollie Appelstein, Eva Block, Evelyn Bloom, Alberta Neun, Arlene Padussis, Margaret Pokorny, Ernestine Stiffman, Sadye Friedman, Mary Shrader, Norma Lee Schwartz and Mary Mills.

Models for the "Not So New" Fashions

Mary DuMez, Margaret Pokorny, Arlene Padussis, Sophie Swiss, Susan Schwartz, Mary Pfeifer, Mary Vincino, Margaret Ohlendorf and Anne Crane.

Dressing Room Aides

Mary DiGristine, Mary Schrader, Dora Rockman and Mary Connelly.

Our thanks and appreciation:

Luncheon at Smithville—Sponsored by Maryland Pharmaceutical Association. Plastic tote bags—secured free of charge, through the efforts of Arlene Padussis

Make-up Mirrors—courtesy of John Crozier, Calvert Drug Company

Dresses for show loaned by—Mary DuMez, Arlene Padussis, Sophie Swiss, Mary Pfeifer, Sadie Wagner and Susan Schwartz

Photography—Evelyn Bloom of Paramount Photo Co.

WEATHER—Warm and sunny, with a bit of a breeze

ATTENDANCE—Could have been better

—Anne Crane
Communication Secretary

Obituaries . . .

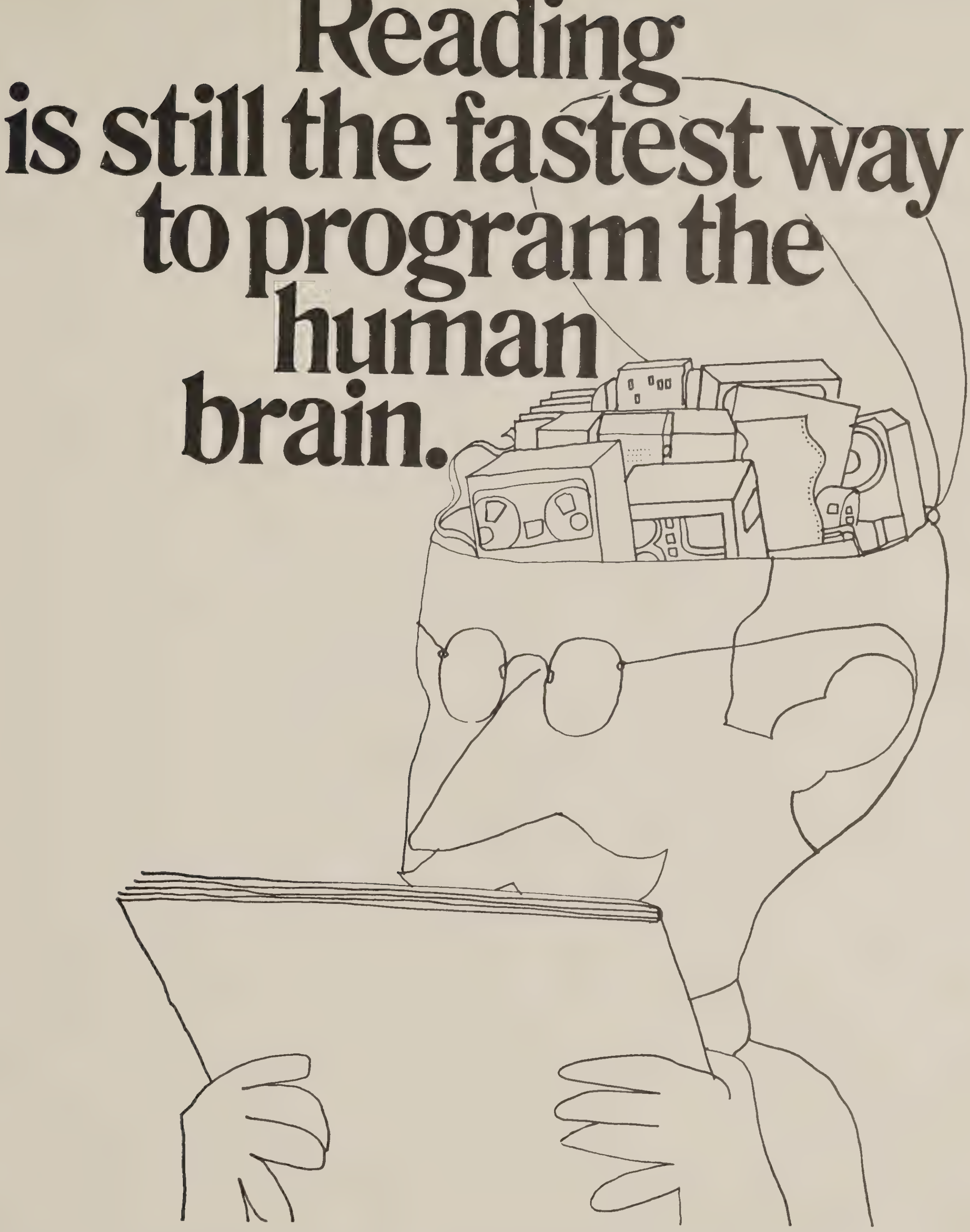
Frederick Minder

Frederick Minder, 79, a retired pharmacist who worked for 18 years at Burris and Kemp Pharmacy on the corner of Greenmount Avenue and 33rd Street, died suddenly on September 28. Born in Baltimore, Mr. Minder received his pharmacy degree from the University of Maryland in 1912. Besides his wife, the former Elizabeth Rosenberger, he is survived by two sons, a sister, and a granddaughter, all of Baltimore.

Morris Levin

Morris Levin, 62, member of MPhA and Baltimore Metropolitan Pharmaceutical Association died September 18, 1970 at the Fort Howard Veterans Hospital after a long illness. He had been a partner in the Mt. Washington Pharmacy, Baltimore with Abraham M. Levy for 24 years. Mr. Levin graduated from the University of Maryland School of Pharmacy in 1929 and was employed with Reads Drug Stores until World War II in which he served in the armed forces. The Mt. Washington Pharmacy was founded by his brother Harry in 1928 from whom he and Mr. Levy acquired it in 1946. He was also a member of Alpha Zeta Omega Pharmaceutical Fraternity.

Mr. Levin is survived by his wife, Ruth nee Simon, and daughters Nancy and Carol; brothers Samuel Levin of Wilmington, Delaware, Benjamin Levin, Las Vegas, Nevada, Harry Levin, Miami, Fla., Israel Levin, Baltimore; and sisters Mrs. Rose Goldstein, Washington, D.C., and Mrs. Elinor Brager of Baltimore.



In an era of "information explosion," how do you "program" information to the human brain? Spoken language is far too slow. The average person speaks about 150 words per minute. Fast readers can read up to 1,500 words a minute—ten times the average rate for the spoken word. Perhaps this is why millions of people regularly purchase from pharmacies, magazines, paperbacks, comics and newspapers from insight and enjoyment.

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Baltimore Metropolitan Pharmaceutical Association

GENERAL MEETING

The September 24th meeting of the Baltimore Metropolitan Pharmaceutical Association was held at the Kelly Memorial Building. The guest speaker was Robert J. Mulhall of the Medical Department of Roche Laboratories whose talk was entitled "Clinical and Pharmacological Aspects of Levodopa Therapy in the Parkinson Patient." The presentation, which included a film strip on Parkinson's disease, was very informative and interesting. Mr. Mulhall went on to answer questions from the audience.

Among the important points which he brought out were: There are about 1.5 million persons in the U.S. who have Parkinson's disease and about half of these cases have been diagnosed. Levodopa has been used successfully in alleviating the symptoms of Parkinson's disease. Drugs which are contraindicated in patients who are taking 1-dopa are MAO inhibitors, the sympathetic amines, tranquilizers of the phenothiazine type and reserpine. Pyridoxine in doses of 10 mg. or more per day is also contraindicated.

President Anthony G. Padussis pointed out the value that a medication record system would have in the detection of contraindicated drugs by the community pharmacist. Executive Director Nathan I. Gruz reported on some of the activities that the Association has been involved in recently, including third party payment programs and Medicaid. In line with current "consumerism" there are increasing complaints from the public about professional and economic practices of pharmacists. Upon investigation, some grievances proved to be a result of misunderstanding. A report of proposed Amendments to the Maryland Pharmaceutical Association Constitution and By-Laws and the MPhA Convention was made.

Charles Spigelmire, Chairman of the Public Relations Committee, reported on National Pharmacy Week, October 4th to 10th. Mr. Spigelmire pointed out that his committee is continuing to emphasize, through the radio, TV and press media, the theme "Your Pharmacist Is Your Best Neighbor."

The installation of BMPA officers will take place on Sunday, January 31st at Blue Crest North. Joseph Dorsch is the chairman of this event.

Bernard B. Lachman spoke on PHARMPAC activities. PHARMPAC, the Pharmacist's Political Action Committee, was formed in 1966, and has been active in encouraging pharmacists to become candidates for public office. Even though pharmacist Donald O. Fedder was defeated for House of Delegates, in the primary election, he made an excellent showing with 6,000 votes. Pharmacist Arnold Amass ran unopposed for nomination as a candidate to the State Senate in the Frederick-Carroll County Legislative District.

Alder Simon, Chairman of the Simon Solomon Pharmacy Economics Seminar, reported that the Seminar would be held at the Warren House, on November 19th, with the theme being "Discounting and Store Management."

Refreshments were served, with Roche Laboratories serving as co-sponsor.

Prince Georges-Montgomery County Pharmaceutical Association

The first meeting of the Prince George's-Montgomery County Pharmaceutical Association for 1970-71 was held on September 23rd at the Hampshire Motor Inn, Langley Park, Maryland.

The main topic was "PHARMPAC—The Maryland Pharmacists Political Action Committee." Nathan I. Gruz, Executive Secretary of the Maryland Pharmaceutical Association spoke on the necessity for unified action on behalf of pharmacy. He pointed out that political action expenditures by organized groups was led by labor, followed by the American Medical Political Action Committee. This contrasts with the very limited expenditure by pharmacy. He outlined major MPhA activities and the benefits other professions and pharmaceutical associations have gained from local, state and national federations.

Donald O. Fedder, President of MPhA, and a candidate for the House of Delegates, from the 2nd District of Baltimore County stressed the need for an all-out participation by pharmacists in political activity. He also reviewed the proposals for Affiliation with APhA and for establishing a House of Delegates structure.

Bernard B. Lachman, immediate Past-President of BMPA and Treasurer of PHARMPAC presented a history of PHARMPAC and the results obtained from its past activities. Anthony G. Padussis, President of BMPA, and Chairman of PHARMPAC and the MPhA Legislative Committee, spoke of the benefits in the legislative and governmental arena of PHARMPAC. He urged support by all pharmacists and the entire drug industry.

MPhA President-elect Nathan Schwartz reported on plans for the 1971 Convention to be held in the Baltimore area. Plans are for a 2-day business convention with banquet and an optional post-convention trip overseas. He stated that consideration is being given to the Washington Metropolitan area as a site for the 1972 Convention.

Arnold L. Amass, Carroll County pharmacist and a candidate for the State Senate was unable to appear as scheduled due to an unexpected political meeting.

Reports were presented from a number of officers and committee chairmen, including President Rudolf F. Winternitz, Secretary Paul Reznek, Treasurer Edward Nussbaum, Scholarship Dinner Chairman Martin Hauer, and Public Relations Chairman Samuel Morris.

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Traveler's Auxiliary Maryland Pharmaceutical Association

The following Officers and Board of Trustees were elected at the meeting held at the Maryland Pharmaceutical Association Convention in Atlantic City:

Howard Dickson	*Honorary President*
William L. Nelson	*President*
Paul J. Mahoney	*First Vice-President*
John Matheny	*Second Vice-President*
Abrian Bloom	*Third Vice-President*
John A. Crozier	*Secretary-Treasurer Emeritus*
William A. Pokorny	*Secretary-Treasurer*
C. Wilson Spilker	*Asst. Secretary-Treasurer*

BOARD OF TRUSTEES

Francis J. Watkins, *Chairman*

Herman Bloom
Joseph J. Hugg
Joseph Grubb
Albert Maranto
John Forbes
A. G. Leatherman
Stuart Baltimore

--The following committees were appointed:

Attendance—Francis J. Watkins, Chairman, Dave Mervis, Joseph Constanza
Custodian—Dick Brauer, Chairman, Charles Maranto, William Grove
Welcome—Leo (Doc) Kallejian, Chairman, Joseph Grubb
Luncheon—Paul J. Mahoney, Chairman, John Fagan
Special Events—Stuart Baltimore, Chairman, Howard Dickson
Program—Larry Rorapaugh, Chairman, Abrian Bloom
Membership—William A. Kolb, Jr., Chairman, Melvin Cernak, Ross I. Lytle, Jr.
Maryland Pharmacist—Herman Bloom, Chairman, Paul Friedel, Dorsey Boyle
Publicity—Ken Mills, Chairman, Howard Dickson, Ed Kabernagel
Welfare—John Cornmesser, Chairman, Ray Schroll
Memorial Fund—Louis M. Rockman, Chairman, Ken Mills
Ways and Means—Joseph J. Hugg, Chairman and Past Presidents

Two Pharmacy School Professors Honored

Dr. David A. Blake, Associate Professor of Pharmacology and Chairman of the Department of Pharmacology and Toxicology, University of Maryland School of Pharmacy and Dr. Ralph N. Blomster, Professor and Chairman of the Department of Pharmacognosy, University of Maryland School of Pharmacy, have been selected to appear in the 1970 edition of *Outstanding Educators of America.*

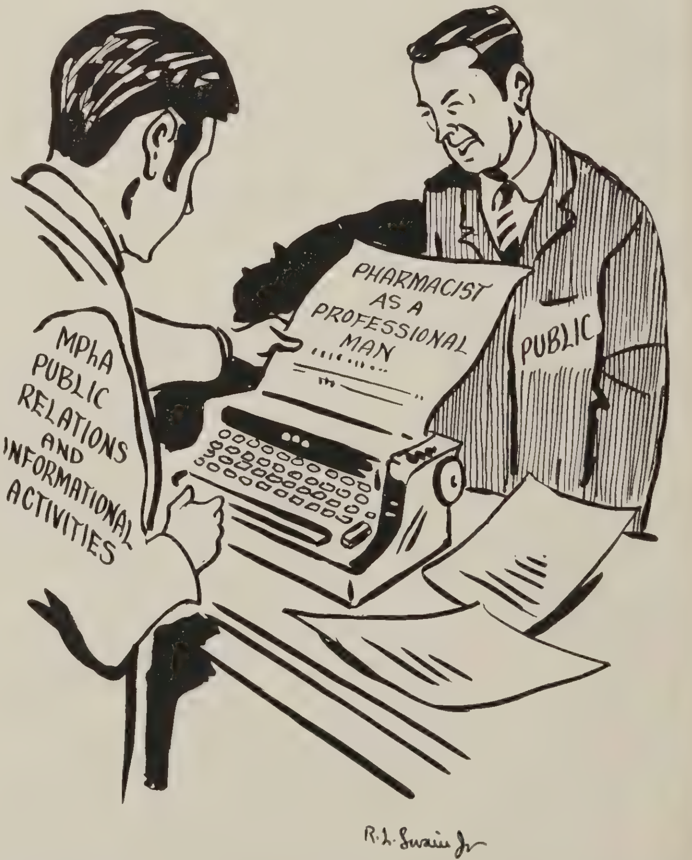
The two professors were nominated on the basis of their civic and professional achievements. More than 5000 of the country's foremost educators are featured each year. Guidelines for selection include an educator's talents in the classroom, contributions to research, administrative abilities, and civic and professional recognition.

Ralph Shangraw Elected to U.S.P. Committee

Dr. Ralph Shangraw, professor and chairman of the pharmacy department of the School of Pharmacy, University of Maryland at Baltimore, has been elected to five-year membership on the Committee of Revision of the U.S. Pharmacopeia and made chairman of the U.S.P. Subcommittee on Formulations.

The Revision Committee consists of 60 outstanding physicians, pharmacists, chemists and other experts qualified to pass upon the merits of drugs and their standards. A new U.S.P. book is published every five years.

Dr. Shangraw, a native of Rutland, Vermont, received his undergraduate training at the Massachusetts College of Pharmacy and his Ph.D. from the University of Michigan College of Pharmacy. He joined the faculty of the University of Maryland in 1958 and was appointed department chairman in 1969. Dr. Shangraw has served on numerous school and university committees and is currently chairman of the Curriculum Committee and of the Committee on Graduate and Postdoctorate Study. During the past 10 years he has directed the research projects of 14 M.S. and 10 PhD. students. Dr. Shangraw has written more than thirty articles in the area of pharmaceutical technology, which have been published in scientific journals.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'Pharmacy Identification Code'

Will Be Developed by NPIC

A "Pharmacy Identification Code" will be developed by the National Pharmacy Insurance Council in conjunction with Fisher-Stevens, Inc.

The Code number will initially indicate the state and actual location of the pharmacy. Features such as size and type of facility are expected to be added.

Pharmacies throughout the country will be directly notified of their "NPIC Number" and will be asked to acknowledge it on a preprinted form.

Pharmacies which open or change address after original assignment will be asked to promptly contact the National Pharmacy Insurance Council in Washington, D.C. for their "NPIC Number."

The program has been designed to provide and maintain an up-to-date list of pharmacies throughout the country on a continuous basis.

Fisher-Stevens of New Jersey was chosen because of its unique position to participate in this project and make a significant contribution based upon its past experience in the pharmacy community as well as its computer know-how.

The significance of the "Pharmacy Identification Code" is far-reaching. When utilized by all third-party carriers and administrators it will help reduce the cost of administration and equipment and speed up payment to pharmacists. Claim identification and adjustment will be greatly simplified.

Agencies administering the state Medicaid programs as well as the Department of Health, Education, and Welfare's Medicare program have need for such identification. The Food and Drug Administration, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and the Veterans Administration have all indicated a need for a pharmacy identification number. The "NPIC Number" will be made available to State boards of pharmacy to utilize as that assigned for licensure and will assist them in updating and maintaining their records.

The project is expected to be operational by early November.

CHAIN STORE REPORT

Drug Fair Posts Record Sales, Earnings for Year

Drug Fair, Washington's second largest chain of drug stores, reported record sales and earnings for its fiscal year ending June 30. Sales reached $125,939,944, a 23 per cent increase over 1969's $102,354,180. Earnings climbed from $1.47 per share to $2.00.

At the end of June, Drug Fair had 120 stores in the metropolitan area against 116 the year before. Since June, the company has opened a store in McLean, Virginia and another in Cambridge, Md. The company is planning to add 10 more new stores in the next 10 months. The other two large Washington drug store chains are People's which is the biggest, and Dart Drug, which ranks third.

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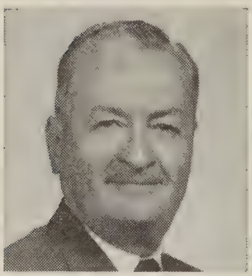
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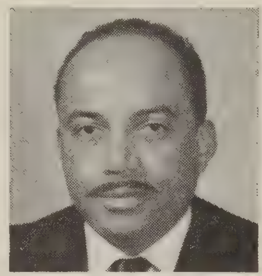
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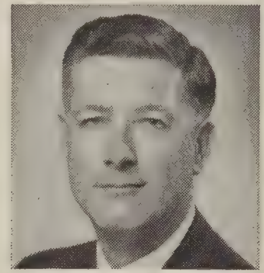
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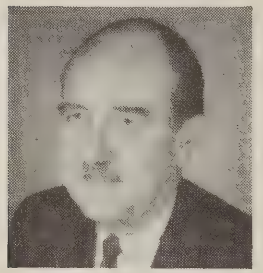
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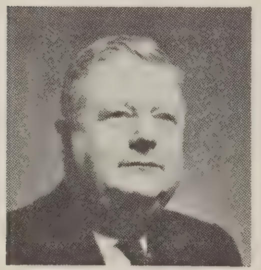
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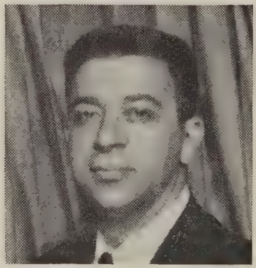
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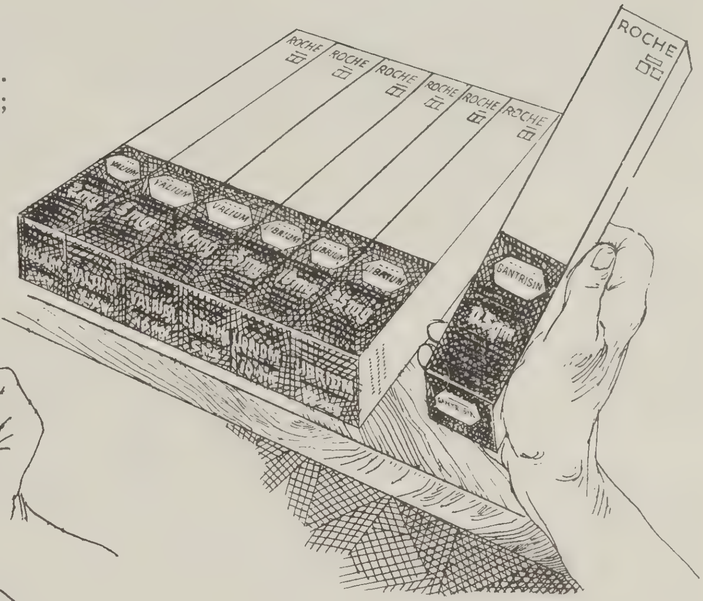
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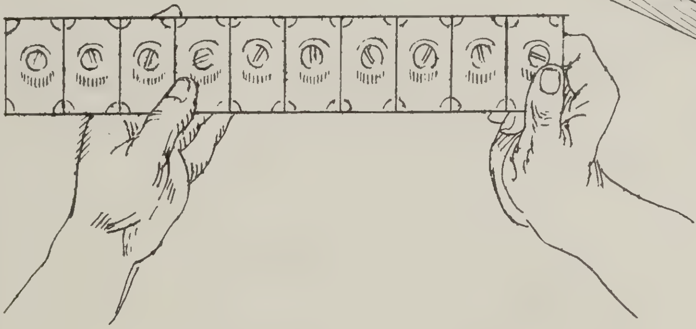

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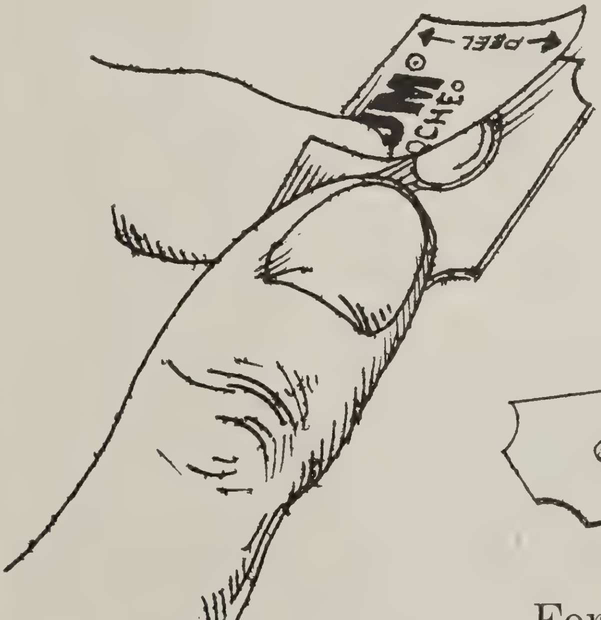

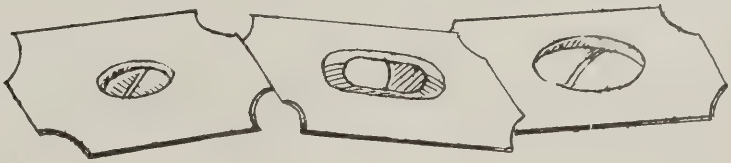

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*Tested were a zinc pyrithione preparation and a product containing hexachlorophene, sulfur and salicylic acid.

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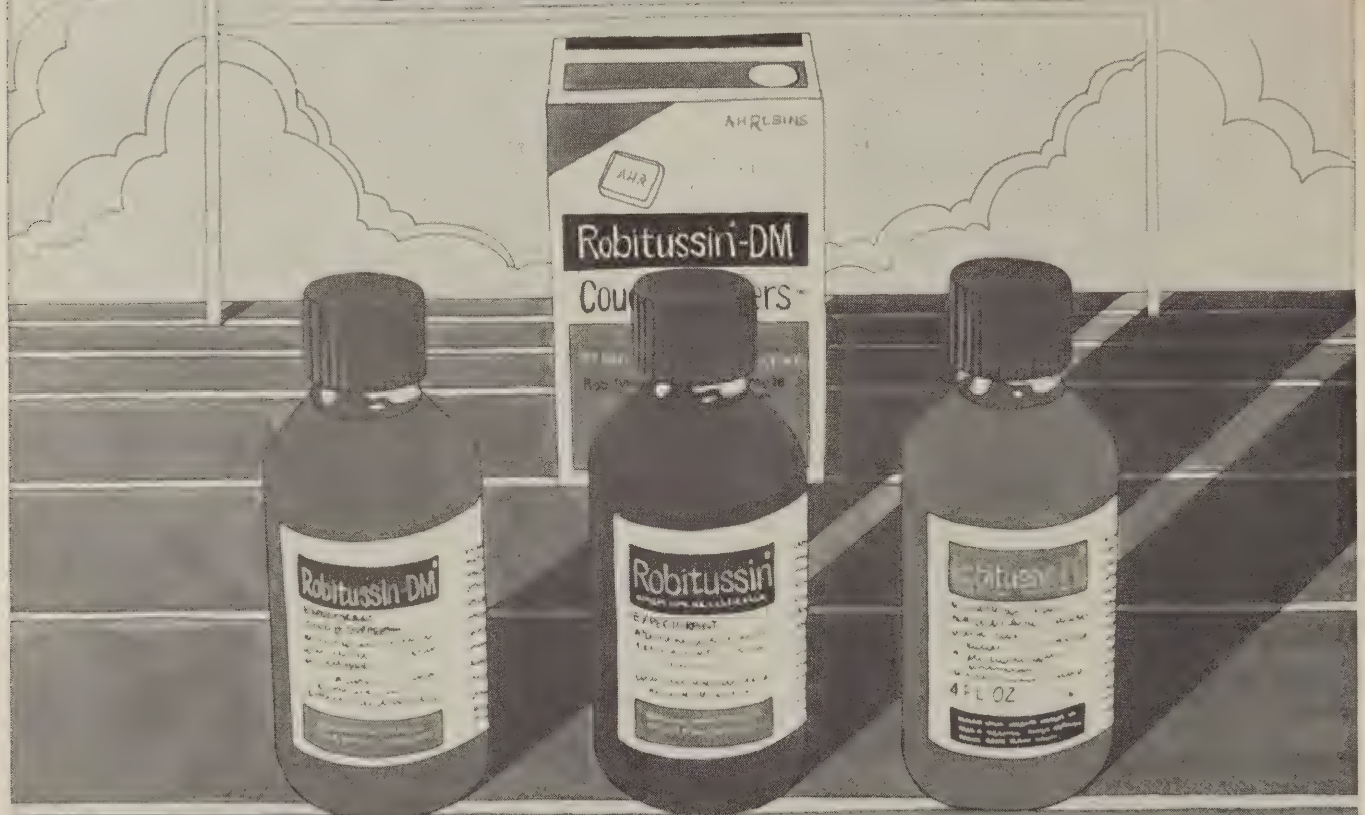
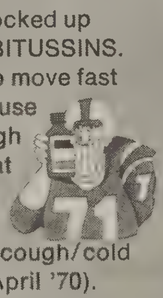


Now, it's your ball

(and we'll help you move it).*



You recruited a team of winners during A. H. Robins' summer deal period when you stocked up heavy with the ROBITUSSINS.

Now, you're set to move fast and score big because you've got the cough preparation line that outsold all others in drug stores during the 1969-70 cough/cold season (Sept. '69-April '70).

Your quarterback? Reliable ROBITUSSIN®, the most durable expectorant in any lineup and one of the 200 most prescribed drugs. Truly an All American!

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Rounding out your hard-hitting foursome is that *solid* performer, COUGH CALMERS™.

A few of you didn't get in on our money-saving deal. All we can say is better luck (and stocking) next year. For the majority of you who did, it's a bet you're set to H-I-K-E sales and profits all during the 1970-71 cough season.

How can your team (and ours) lose when you're such a good manager, Mr. Pharmacist?

***HERE'S HOW WE'LL HELP YOU MOVE IT:**

Heavy M.D. detailing and promotion, in-store displays, ads in Parents' magazine.

A. H. Robins Company,
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MARYLAND PHARMACEUTICAL ASSOCIATION
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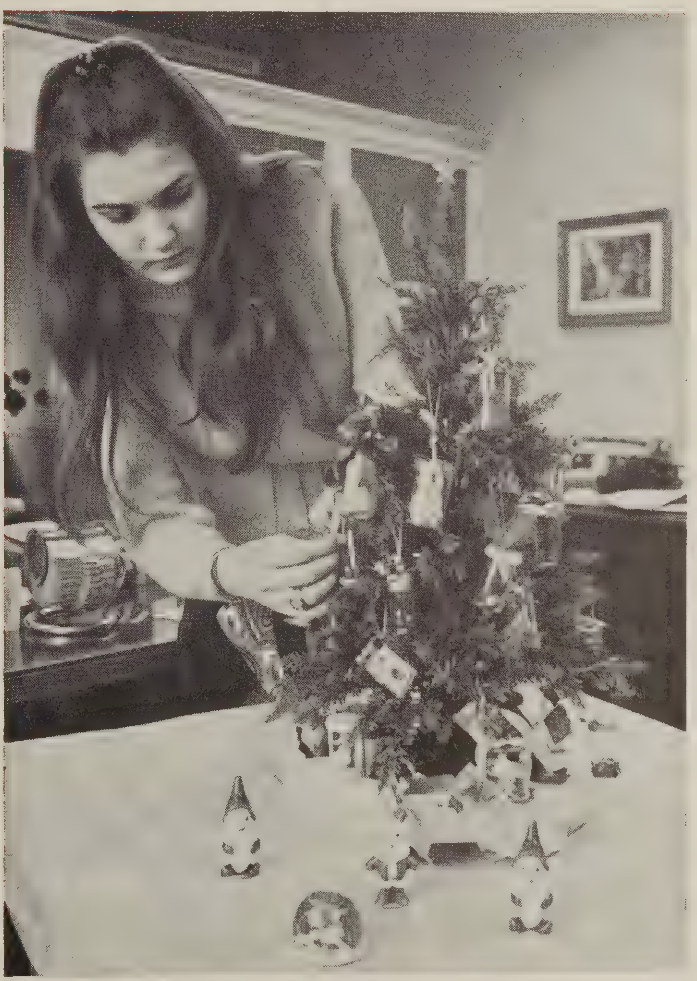
the maryland pharmacist

Season's Greetings



This Christmas Tree, at the Maryland Pharmaceutical Association headquarters office, is trimmed with ornaments using prescription plastic vials and boxes. The charming and imaginative handicraft was created by Mrs. Richard Crane, who is the Communications Secretary of LAMPA (our Ladies Auxiliary) and the wife of a pharmacist medical service representative. Miss Hazel R. Pfister, of the MPhA staff, is trimming the tree.

Volume 46 NOVEMBER 1970 Number 11

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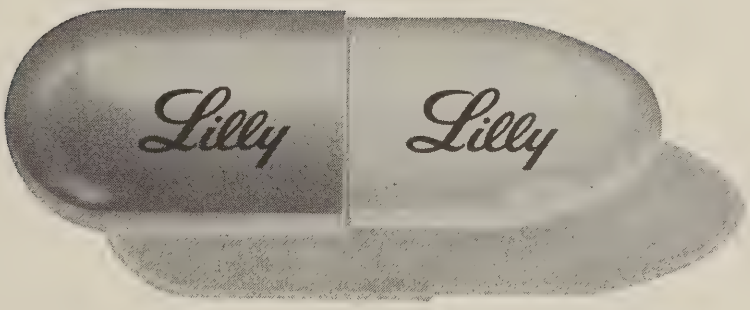

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The Maryland Pharmacist

NATHAN I. GRUZ, *Editor*
650 WEST LOMBARD STREET

NORMAND A. PELISSIER, *Assistant Editor*
BALTIMORE, MARYLAND 21201

MARYLAND PHARMACEUTICAL ASSOCIATION

VOLUME 46 NOVEMBER 1970 NUMBER 11

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Editorial . . .

Affiliation–Pathway To Strength

Mandate For Unity In Pharmacy

It has been said "there is nothing so powerful as an idea whose time has arrived." Perhaps we can apply this aphorism today, to what is known in pharmacy as the issue of "affiliation." Perhaps "reciprocal membership" and "federation" should be used as terms which are not as emotion laden in the context of the politics and prejudices in pharmacy.

At any rate, after many years of heated discussion and long debate, the Maryland Pharmaceutical Association has voted to "affiliate" with the American Pharmaceutical Association.

For years many pharmacists, including the leadership, had been led to believe that there was considerable opposition to "affiliation" in Maryland. However, the passage of time and the march of events worked their change upon the thinking of pharmacists concerned with the future of the profession. Perhaps it should not be too surprising then that a mail ballot showed 220 in favor of affiliation and only 35 opposed.

Gratifying, too, has been the decision of the second largest local society—the Prince Georges-Montgomery County Pharmaceutical Association to affiliate with MPhA.

With local-state affiliation about 95% complete in Maryland and with the overwhelming mandate from the membership to implement MPhA-APhA affiliation for 1971, the foundation has been laid for a strong, unified organizational structure for pharmacy in Maryland.

Now all pharmacists in the state have a clear-cut challenge. The challenge is to effectuate the commitment of every pharmacist to our emerging federated structure.

This challenge is the opportunity so many of us have dreamed of, hoped for, worked for:

> To forge a truly united profession which will provide the wholehearted support necessary to produce adequate resources and dedicated staff for an effective organization.
>
> Affiliation is, of course, only a tool but not operative without the large majority of pharmacists as members.

There is a core of devoted members who have assumed great responsibilities and heavy burdens for many years. Now is the time for large infusions of supporters and participants from the ranks of alienated, indifferent and apathetic pharmacists.

The present membership has the capability to help bring the uncommitted into the ranks of MPhA for the mutual benefit of all.

Can we count on *your* help?

—Nathan I. Gruz

Drug Costs Increase Very Little Amidst Spiraling Health Care Costs

Medical costs, on the whole, have risen by 32 per cent in the past five years—but there are wide differences in the individual items that make up a family's health-care budget.

A day's care in a semiprivate hospital room, for example, has gone up 88 per cent since 1964. But the index of drug prices is up hardly at all—and many individual items are cheaper than in 1964.

The cost of all drugs, including prescription and over-the-counter items, has risen an average of only 1.2 per cent in the past five years. Competition and the economies of mass production, in fact, have cut prices of such items as vitamin tablets and many antibiotics.

Price Changes in Past Five Years (1964-1969)

Hospital room, semiprivate	UP 88%
Hospital room, private	UP 80%
Hospital operating room	UP 68%
Children's doctor, office visit	UP 44%
Physician, office visit	UP 39%
Having a baby	UP 35%
Filling a tooth	UP 31%
Psychiatrist, office visit	UP 30%
Pulling a tooth	UP 28%
Dentures, full upper	UP 28%
Removing tonsils	UP 28%
X-ray, including diagnosis	UP 24%
Hernia operation	UP 24%
Eye examination and glasses	UP 21%
Routine lab tests	UP 18%
Sedative drugs	UP 15%
Cough syrup	UP 11%
Cold tablets	UP 8%
Aspirin	UP 7%
Multivitamins	DOWN 6%
Anti-infection drugs, Rx	DOWN 22%

SOURCE: *U.S. News and World Report,* March 16, 1970

PHARMACY CALENDAR

January 14—MSHP monthly meeting, Mercy Hospital, Baltimore. Dinner at 6:00 P.M. Speaker—Dr. Joseph A Mead, Chief of Ambulatory Services and Acting Chief of Medicine, Mercy Hospital. Topic—"New Concepts in Ambulatory Care."

January 31—Baltimore Metropolitan Pharmaceutical Association Annual Installation Banquet and Dance, Blue Crest North.

February 11—Swain Pharmacy Seminar, Good Samaritan Hospital. Theme—"Pharmacy in the 1970's".

February 11—MSHP monthly meeting, Good Samaritan Hospital.

March 27-April 2—APhA Annual Meeting, San Francisco, California.

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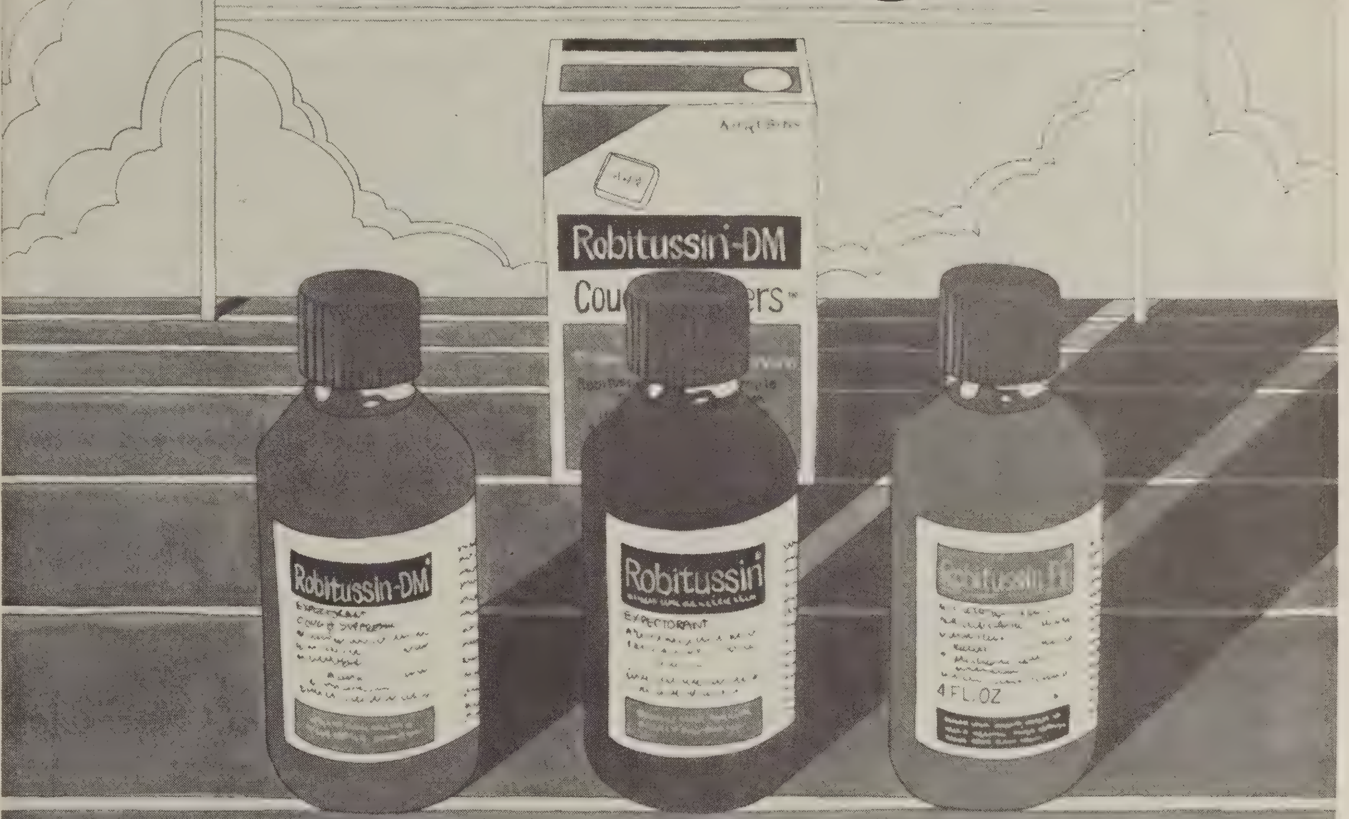

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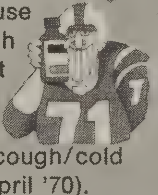

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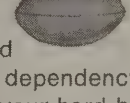

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A. H. Robins Company,
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A·H·ROBINS

President's Message . . .

Your association represents you . . . or does it?

December is upon us and half the association year is gone. We have had some important amendments passed by our membership that will surely aid us in all our activities for the coming decade.

Foremost of these is the organizational changes voted by you at the convention and ratified at the Fall Regional, establishing a House of Delegates. The House of Delegates coupled with local-state affiliation, will assure a more responsive association leadership. With your support and participation, we now can truly expand our horizons.

All of us in pharmacy have been crying for a strong, unified voice, not only within our State, but nationally. I feel that you have taken a giant step in that direction by approving affiliation of the Maryland Pharmaceutical Association with APhA. It is now incumbent upon all of us to make our voices heard. Maryland will have an increased number of delegates to the APhA House of Delegates meeting at the convention in San Francisco in March. Let me know your thinking on all of the issues facing pharmacy both locally and nationally.

Many things remain to be done. Our communications system, although improved somewhat, needs further strengthening. We need the active participation of all of the Pharmacists in Maryland. This can only come about by the active commitment of each of you who are dues paying members—to get just 2 new members by January 31, 1971. Pharmacy in Maryland is moving strongly ahead. Join with us!

I have visited many of the local associations in the past several weeks and will continue to do so.

I would like to thank each of you who participated in my recent election campaign. Your encouragement and support is a source of great satisfaction to me.

With the approach of the Holidays, my family and I wish each of you the Joys of the Seasons and a Healthy, Happy New Year.

— Donald O. Fedder

Full Line Discount Stores Increase In Number

The retailing business in the United States is changing and changing rapidly. Fourteen thousand stores were squeezed out of business last year, bringing the five-year out-of-business toll to 52,000.

The relationship of stores to population has changed from one store for every 97 persons in 1958 to one per 110 in 1963, one per 112 in 1966, one per 115 in 1968 and now has reached one per 121. This indicates that larger stores with wider merchandise selections are replacing the corner enterprise stores at a faster rate than ever before.

General merchandise retailers thus gain importance in the changing marketplace and they account for the largest increase in this year's census. The full line discount store, for example, grew by 600 units in the past year for a total of 4200. This represents an increase of 16.7 per cent over 1969 and nearly double the count of 2200 stores in 1966.

BMPA 55th Annual Installation Dinner Dance

The 55th Annual Installation Dinner Dance of the Baltimore Metropolitan Pharmaceutical Association will be held on Sunday, January 31, 1971 at the Blue Crest North. Joseph U. Dorsch, BMPA Vice President is Chairman.

Chairman Dorsch announced that the affair will feature the finest in every item of the program: food, beverages, music, vocalist and other arrangements.

An outstanding personality will be present for a brief address.

Tickets will cover valet parking, checking service, set-ups and open bar after dinner.

The cocktail hour will begin at 5:30 P.M. with dinner at 7:00 P.M. Coffee and danish will complete the evening at closing time.

Chairman Dorsch promises many valuable surprises and urges all associated with pharmacy to make early reservations.

Tickets may be obtained by calling the Ticket Chairman, George Stiffman at 542-7933 or the BMPA office at 727-0746.

Call your friends and make up a table. You will be glad you came.

Pharmacy Changes . . .

The following are the pharmacy changes for the month of November:

New Pharmacies

Drug Fair No. 136, Milton Elsberg, President, 312 Hospital Drive, Glen Burnie, Maryland 21061.

Lawson Nursing Home Pharmacy Service, Alfred M. Lawson, President, 6005 Landover Road, Cheverly, Maryland 20785.

Sentry Drug Store, Philip & Marcia Bogash, 140 Village Shopping Center, Westminster, Maryland 21157.

No Longer Operating As Pharmacies

Peoples Service Drug Store No. 196, G. B. Burrus, President, 8101 Barlowe Road, Palmer Park, Hyattsville, Maryland 20785.

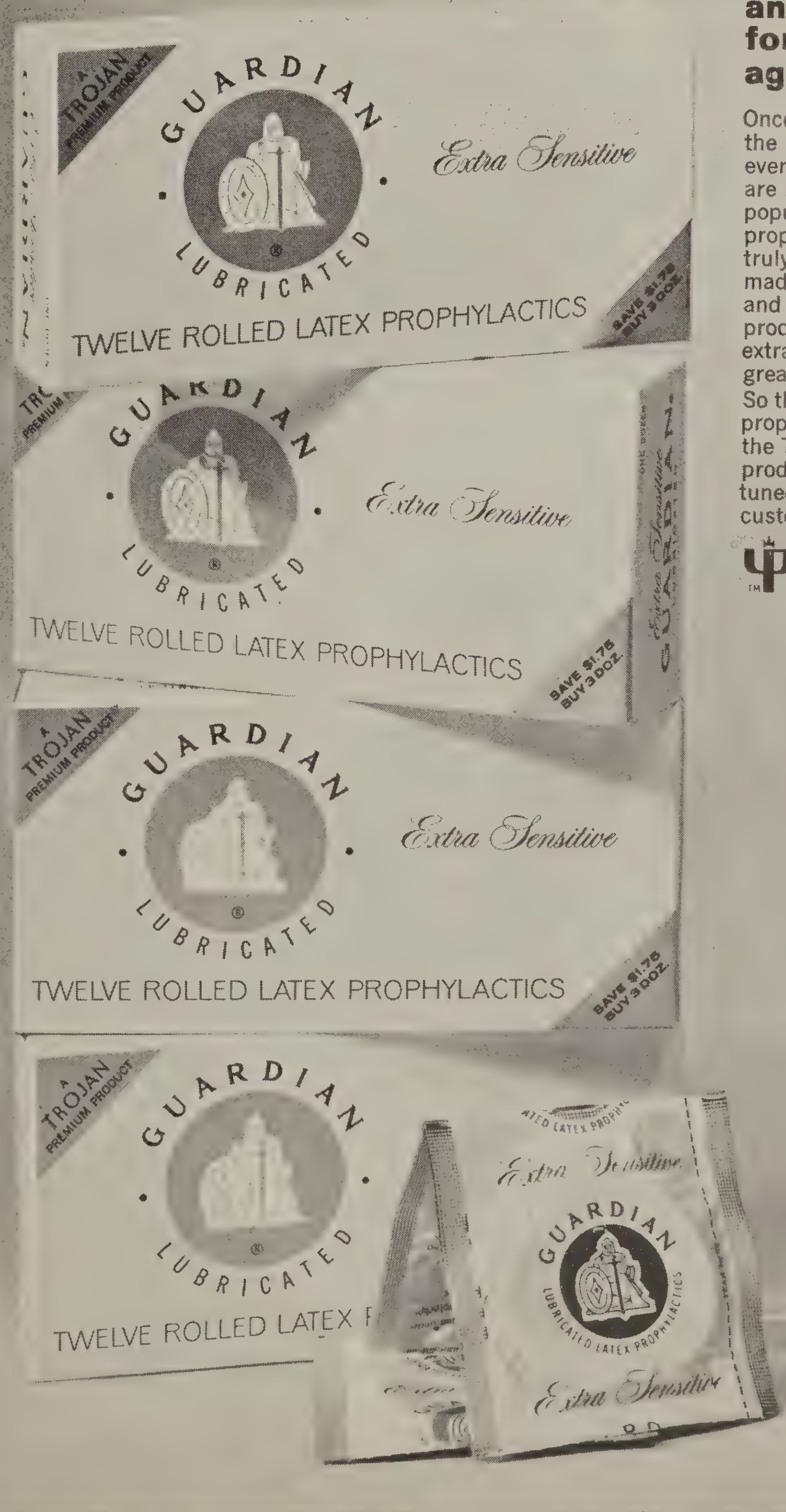
Changes Of Address, Ownership, Etc.

Chandler's Drugs, Inc., Nehemiah W. Chandler, President, 7037 Annapolis Road, Landover Hills, Maryland 20784.

Dolfield Pharmacy No. 2, Inc., Howard Pollack, President, 5024 Park Heights Avenue, Baltimore, Maryland 21215.

North Point Pharmacy, Donald Levy, 7568 North Point Road, Baltimore, Maryland 21219.

Sell him Guardian®


A TROJAN PREMIUM PRODUCT
GUARDIAN
LUBRICATED
Extra Sensitive
TWELVE ROLLED LATEX PROPHYLACTICS
SAVE $1.75 BUY 3 DOZ.
LUBRICATED LATEX PROPHYLACTICS

and he'll never ask for just prophylactics again

Once a customer uses Guardian, the chances are he'll ask for them every time. Lubricated prophylactics are becoming increasingly more popular every day, and Guardian prophylactics are by far the finest truly lubricated rubber prophylactics made. They're extra sensitive, thin, and sealed in foil—an excellent product for your customer. Plus, the extra profit makes Guardian a great product for you to sell.

So the next time he asks for just prophylactics, sell him Guardian, the Trojan brand premium lubricated product from Youngs, the company tuned to today's pharmacy customers.

Youngs Drug Products Corporation,
Piscataway, New Jersey 08854

Now Gantrisin® (sulfisoxazole) joins the Roche Tel-E-Dose™ family.

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ROCHE
Tel-E-Dose VALIUM
diazepam
5 mg
Tel-E-Dose LIBRIUM
chlordiazepoxide HCl
25 mg
Each capsule contains 25 mg chlordiazepoxide hydrochloride
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sulfisoxazole ROCHE
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sulfisoxazole ROCHE
0.5 Gm

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Tel-E-Dose^T.M.^ makes it easier for you and everyone else concerned.

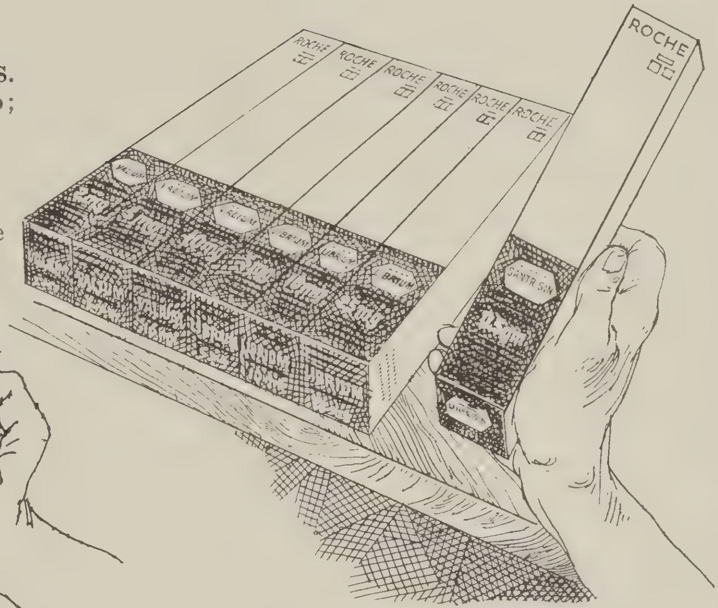
For the pharmacist

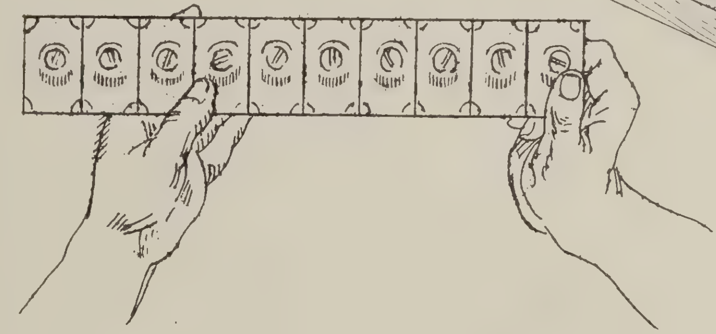
Easy to stack, store and identify cartons.

Ten sealed unit-doses to each convenient strip; ten strips to the box.

Less Waste.

Unused, sealed medication can be returned to the pharmacy and used again later. Helps expedite inventory control, too.





For the nurse

Sanitary, easy to open, pleasant to administer.

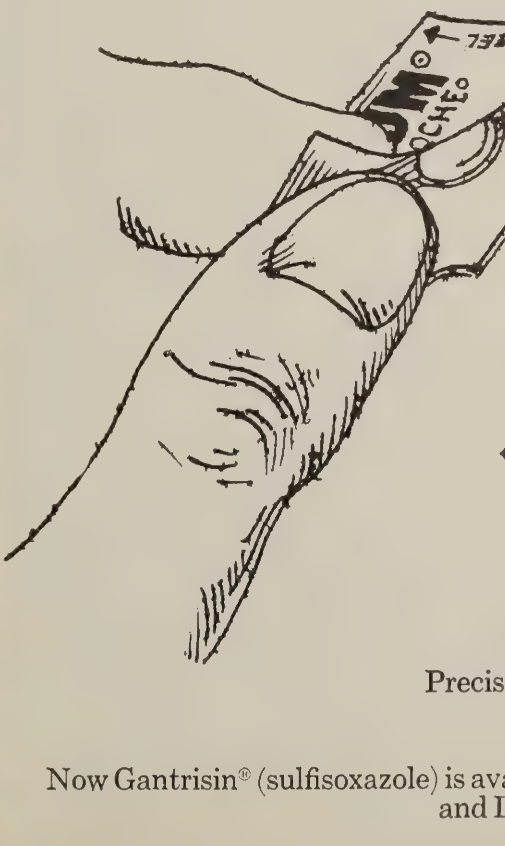
Each Tel-E-Dose unit package opens from all four sides—becomes its own little serving cup.

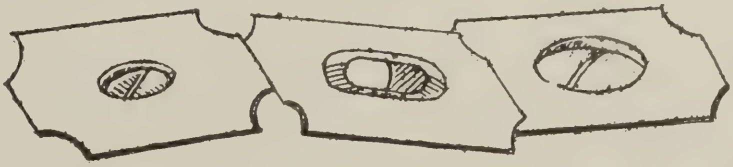
Less risk of dosage and medication error.

Each unit-dose is plainly and completely identified—clearly labeled with control number and expiration date.

Saves time.

Eliminates need for transferring tablets from stock bottles to medication cups.





For the doctor

Precision follow-through of drug orders.

Now Gantrisin® (sulfisoxazole) is available in Tel-E-Dose packaging along with Valium® (diazepam) and Librium® (chlordiazepoxide HCl).

The Role of the Pharmacy Technician in Community Pharmacy

"The Role of the Pharmacy Technician in Community Pharmacy" was presented by Russell A. Benedict, on April 17, 1969 at the Spring Regional Meeting of the Maryland Pharmaceutical Association which was held at the Chestnut Ridge Country Club, as part of a panel discussion on "The Role of Supportive Personnel in Pharmacy."

Volumes have been written concerning the role of the pharmacy technician in the future, and we shall confine our remarks today as to how this sub-professional or supportive personnel fits into the picture, insofar as community pharmacy is concerned.

There isn't a day that passes that we don't read about the need for the pharmacist to become "patient oriented." We are told that he must broaden his horizons in order that he may more fully exercise his responsibilities as a health professional.

While we wholeheartedly agree with the concept of becoming involved in patient care to a much greater degree than in the past, we cannot look upon what some choose to call "the simple delivery of a drug to the patient" as a task which is to be considered beneath the status of the professional. On the contrary, by virtue of the fact that our license to practice pharmacy is granted to us by the public to whom we owe our first allegiance, the best interests of "that public" are not going to be served by delegating to others those tasks which demand the attention of the pharmacist.

There is no question about it . . . there are some manipulative functions which the pharmacist has traditionally performed which can be assumed by the sub-professional, not necessarily in the interests of economy, but out of sheer necessity. Let's take a prescription pharmacy in a town of 20,000 people which is open daily from 9 A.M. to 9 P.M., from 9 A.M. to 7 P.M. on Saturday, and from 10 A.M. to 1 P.M. on Sundays and Holidays. It is doing from 75 to 80 per cent of its total volume in prescriptions and allied medical needs, and it employs a total of 5 people. Two are full-time pharmacists, two are girls who would normally be considered as drug clerks in the eyes of the public, and the fifth employee is a full-time delivery man, stock-clerk, and general all 'round clean-up man. All of the personnel work 40 hours per week.

The pharmacy is filling an average of 100 prescriptions daily with about 40% of them being refills. It is filling one Rx for every 7 minutes that its doors are open. Now we'll look at what we mean by the term "total prescription" . . . from the time it is called in, brought in by the patient, or until the pharmacist has contacted the physician . . . to the time that it is delivered to the waiting patron in the pharmacy. We find 15 different manipulative functions involved here, and the $64.00 question is . . . which of these duties can be safely performed by supportive personnel?

	R.PH.	Technician
1. Take Rx on phone	*	
2. Type up the Rx	*	
3. Select drug or drugs needed	*	
4. Price and fill Rx	*	
5. Check to see if additional stock is needed		*
6. Put item on wantbook if necessary		*
7. Put unused portion back in stock		*
8. Type the label (optional)	*	
9. Check label against Rx for accuracy	*	
10. Affix label to the container	*	
11. Cover label with scotch tape	*	
12. Pull Family Rx Record from files		*
13. Check Family Rx Record for allergies and/or contraindications	*	
14. Type information on record card	*	
15. Put record card back in the file		*
16. Take Rx to the patron for consultation and any special directions	*	
17. If a charge, add any additional purchases, or if cash, ring up transaction.		*

We have found a total of just 6 manipulative functions which we in our pharmacy would permit to be assumed by the sub-professional, and which required little or no supervision by the pharmacist.

We have found in a time study, that the functions just described would result in an average savings in time for the pharmacist of approximately one minute for each prescription, for a total of 100 minutes per day, thereby permitting him enough time to fill an additional 33 prescriptions in a 12 hour day. Needless to say, the time saved at the wrapping counter from the time the sub-professional takes over from the pharmacist can vary from as little as a minute to as much as 5 minutes or more.

The question that pharmacists must ask themselves however is this, in view of the fact that many otc ethicals are products which should be sold only under the direct supervision of the pharmacist, because of their contraindications and side effects which demand that adequate warnings be given to the patron . . . is the pharmacist completely patient oriented if his professional services are being provided only to the prescription patron. Certainly, a considerable amount of each working day must be spent in this area, if the ultimate best interests of the patron are considered important.

Some of the most energetic proponents of the pharmacy technician are the giant corporate entities who employ hundreds of pharmacists and who can see this as a

got a cold?
CONTAC
CONTAC
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Contac® sells so fast you could run out!

Go ahead! Display Contac. But keep enough on hand.
We don't call it pharmacy's fastest-selling cold product for nothing.

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way to curtail overhead costs. Some of them see a "two for one ratio," in which there will be as many as two sub-professionals for every pharmacist behind the prescription counter . . . each of them wearing a white coat and each performing the same identical task . . . that of turning out the finished prescription on an assembly line basis.

If we take a long look at the prediction of two billion prescriptions filled by 1975, it would appear that the time saved through the use of supportive personnel will not be sufficient to fill the additional prescriptions which are going to be written. And in addition, with the greater numbers of prescriptions will come a greater demand upon the pharmacist's time in his roll as a drug consultant.

With the advent of third party payments on a scale which may be as much as 75% by 1975, paper work will become as time-consuming as the compounding of the prescription. Unless additional personnel are hired to do this job, the supportive personnel who formerly relieved the pharmacist of some of his manipulative functions will have to be pressed into service in a new roll as "keeper of paper work," and the problem of insufficient help will continue to be with us on an even larger scale.

What does this mean in your future as a community pharmacist? It means that you are going to have to streamline your complete operation in order to make more efficient use of your time and that of your supportive personnel.

The experts say that if technicians are to be utilized in the future, the public safety is not endangered providing adequate supervision is exercised. The question is, where will the supervision come from if the predictions of our statisticians become a reality. Lets take a look at their predictions:

1. The nation will require 7200 more pharmacists by 1970, with 4300 of these needed just to keep up with the attrition rate.

2. The present deficit now runs 700 pharmacists per year and there is no hope for any substantial improvement in that picture within the next few years.

3. Are we not facing a situation in which there will not be enough professionals to adequately supervise the sub-professionals, in the event they are asked to perform more and more of the tasks normally assumed only by the pharmacist?

4. This distinct possibility does exist and could open the door to the mis-use of the sub-professional to the detriment of the profession and to the public health which it is pledged to protect.

5. As pharmacists, our No. 1 concern in the use of the sub-professional is to make absolutely certain that no function is performed without adequate supervision, otherwise the health and safety of the patron could be in jeopardy.

One distinct possibility presents itself, with the advent of vastly increased prescription writing, COUPLED WITH a decrease in the number of pharmacists needed to adequately provide these professional services, there may come out of necessity, a marked reduction in the number of vital services normally performed by the community pharmacy. One of the first to go would in all probability be the most valuable, aside from the filling of the prescription, and that would be the Family Rx Record. Even today, some who are using such a record system have found themselves too busy to make the necessary entries on the card, and have either permitted the service to be performed at the end of the day by a non-professional or have allowed the task to be put off for days at a time, thereby negating a service, which is so vital that it might well save a life. Some pharmacists look upon the Family Record Card as just a means of keeping tract of the family purchases for insurance or income tax purposes, and they lose sight of the real meaning of this valuable service.

Time studies have shown that it takes approximately a minute to retrieve the Family Rx Card from the file, insert into the typewriter, fill in the necessary information, and return to the file, which means that if you are filling 100 prescriptions a day, it is going to take one hour and forty minutes to provide this service.

The elimination of one professional service which cannot be justified under any circumstances and which is second only to the filling of the prescription in the eyes of the patron is that of the actual delivery of the medication to the waiting patron. This service is a must if correct dosage and proper utilization of the medication is to be assured. This is one task that cannot be delegated to a sub-professional anymore than the office nurse would be expected to give the diagnosis to the patient. And while we are about it, what of the prescription that is going to be delivered? How do you communicate with this patron . . . we suggest that pharmacists have made up for them by their printer, a series of short and to the point messages which might apply to any given situation and which could be attached to the outside of the label with a rubber band. One might read, (in the event the physician did not so indicate on the label) "take 45 minutes before the meal," and another "take until all medication is gone," or "Caution: do not use if driving or operating machinery," and so on. Only in this way will you be providing the same "patient oriented" service that you are giving to the patron who picks up the prescription in the pharmacy.

In order to meet the challenge of the 70's, the pharmacist must make more effective utilization of his professional services thru the streamlining of the prescription department. While there is a limit as to the number of Rx which any one man can *safely* fill during an 8 hour day, it is possible to increase ones efficiency by at least 25% thru the adoption of modern business methods and thru rearrangement of files and drug stock. Here are some of the ways this can be accomplished.

For a starter, we suggest that you avail yourself of one of the "hands free" devices which are available for a modest monthly fee from your telephone company. For those of you who are unfamiliar with this indispensable device, let me say that it is "smaller than a bread box" . . . as a matter of fact . . . it's about 4 inches high and 8 inches long. Another way to effect great savings in time is thru the rearrangement of the Rx files in order that they are convenient to the telephone and to the compounding area. For time-wasters, nothing is more aggravating than the constant request for receipts for Rx filled during a specific period, sometimes as long as a two year period, which are needed to satisfy either the Insurance Co. or the IRS, and at times, as much as 15 to 20 minutes was spent doing research and putting it in writing. We solved that problem completely with the purchase of an Apeco Copying Machine and the help of the Family Rx Record. In a matter of seconds, we could supply a copy of all the needed records, and in the event certain portions were not needed to satisfy the claim, we simply lined them out.

Without fear of contradiction, we can say that the No. 1 timesaver in your prescription practice is an electric typewriter which is operated by an expert . . . one who is capable of turning our perfect labels at the rate of at least 40 words per minute. I am fully aware of the fact that many pharmacists do not fit into this category. Another time saving device which cannot be overlooked is the push-button telephone, a device which can save many hours each year. We learned from personal experience that the average time required to dial is 10 seconds, but with the push-button phone, the time is cut in half. This savings, while not great, does amount to five minutes per day in a pharmacy making some 50 calls, and adds up to a savings of 30 hours a year . . . enough time to permit the filling of an additional 450 prescriptions.

In closing, let me say that I sincerely believe that the next decade is going to be a time for all good men to come to the aid of their profession, and if we would be deserving of the title of professional, and if we would continue to serve as "captain of the ship of pharmacy," we must resist the efforts of those who would have us delegate away to others certain responsibilities and prerogatives as to pharmaceutical practice because they find a starting salary of $225.00 a week more than they want to pay for professional services.

We must not listen to those forces who would downgrade pharmacy as it is now practiced and who make light of the "simple act of dispensing" . . . an act which only the pharmacist is licensed to perform. Almost 40 years in pharmacy has convinced me that the patients' best interests are served when the pharmacist is involved with as much of the total prescription as is humanly possible. If we will but make better use of our time through the steps that have been outlined here today, we can continue to be involved and at the same time expand our role in the future as a "true professional."

A Student's Thoughts

The new bag of Pharmacy School is clinical pharmacy and its offspring, patient orientation. When one says "turmoil and change" in pharmacy, one means the curriculum changes and the conceptual changes which are being undertaken to allow the adequate training of those who will be expected to practice clinical pharmacy and to think in terms of patient orientation. This, however, is not as new and tumultuous as it may seem. There are, in fact, many practicing pharmacists who have contributed much and derived much from using these so-called new ideas as a basis for their work. It is certainly possible that this "turmoil and change" is actually a return to the patient and not a discovery of him. Is it not conceivable that we are in a stage of economical diversification which has led us away from the patient and to the realization that perhaps we should return to that patient?

It is too easy to take pharmacy at its face value of counting and pouring. We realize this and you should. Take time out to give yourselves direction and to form some concrete thoughts about pharmacy never forgetting your role as a person serving a purposeful function in your community.

(from *PILL POST*, newsletter of Phi Delta Chi, University of Maryland School of Pharmacy).

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Hospital Pharmacy Section

Preparation of Solutions For Parenteral Hyperalimentation

by Normand A. Pelissier,
Staff Pharmacist, Union Memorial Hospital,
Baltimore, Md.

A number of articles describing the history and rationale of hyperalimentation have appeared in the literature (1-4). Briefly, hyperalimentation can be defined as the intravenous administration of sufficient quantities of the necessary nutrients to maintain a positive metabolic state. Parenteral hyperalimentation may be employed in:

1. Surgical complications which render the gastrointestinal tract functionless, such as fistula, obstruction, and peritonitis.
2. Preoperative preparation of patients who are malnourished and unable to eat.
3. Gastrointestinal diseases which benefit by rest, such as ulcerative colitis and regional enteritis.
4. Preoperative preparation for major surgical procedures associated with a high morbidity.
5. Malabsorption.
6. Diseases which benefit by adequate nutrition, but in which, because of peculiarities of the diet and a restricted volume of intake, such as in liver and renal failure, the nutrients are more easily administered parenterally.
7. Conditions associated with anorexia and inability to eat, such as carcinomatosis, cancer chemotherapy, anorexia nervosa, and cerebrovascular accident.

Solution Formulas

Prior to starting a patient on parenteral hyperalimentation therapy, physicians will often contact the pharmacy department for their advice on how the solution should be ordered. To be able to discuss these formulations intelligently with the physician, the pharmacist must be acquainted with some basic information which applies to these solutions. Essentially, these solutions consist of varying proportions of protein hydrolysate and dextrose. The optimum ratio of nitrogen to non-protein calories when both are administered parenterally is 1:150(5) to 1:200 (6). A liter bottle of 5% protein hydrolysate solution contains the equivalent of approximately 38 Gm. of protein or approximately 6 Gm. of nitrogen. (The ratio of nitrogen to protein is 1:6) (1). To prepare a solution with a nitrogen to non-protein ratio of 1:150, each liter of 5% protein hydrolysate solution would have to have 900 non-protein calories added to it. The caloric value of dextrose being 3.4 calories per Gm., this would mean 265 Gm. of dextrose or 530 ml. of 50% dextrose solution combined with 1000 ml. of 5% protein hydrolysate solution would result in a nitrogen to non-protein calorie ratio of 1:150. In practice many hospitals use a 5% protein hydrolysate solution which already contains 5% dextrose and allowance is made for the extra dextrose.

Electrolyte Content

When adding electrolytes to these solutions it must be understood by both pharmacist and physician that the protein solutions already contain certain quantities of electrolytes. The concentrations will vary depending on the particular manufacturer.

millequivalents per liter

Product	Manufacturer	Sodium	Potassium	Calcium	Magnesium	Chloride	Phosphate
Amigen 5%	Baxter Labs	35	18	5	2	20	30
Hyprotigen 5%	McGaw Labs	25	20	5	2	18	25
Aminosol 5%	Abbott Labs	10	17	*	*	17	*

* No significant amount

Milliosmole Calculation

SOLUTION	mOs. per Liter
Dextrose 5%	252
Protein Hydrolysate 5%	approx. 360*
Protein Hydrolysate 5% with Dextrose 5%	approx. 610*
Alcohol 5%	850

*depending on manufacturer

Plasma contains approximately 290 milliosmoles per liter. Solutions containing approximately this concentration of milliosmoles per liter are considered isotonic.

In calculating the caloric value of protein solutions, uses a figure of 3.5 calories per Gm. of protein hydrolysate(7). The dextrose as was mentioned above, supplies 3.4 calories per Gm. It should be mentioned that various manufacturers prepare their solutions from different protein sources. McGaw and Baxter utilize casein hydrolysates while Abbott's product is a modified fibrin hydrolysate.

Preparation of Solutions

Several methods of preparing solutions for parenteral hyperalimentation have been described in the literature. The system described by Pike, et. al.(8) makes use of a sterile blood recipient rubber-stoppered flask which has a high vacuum. The protein hydrolysate and dextrose are drawn into the plasma-vac flask via a blood recipient set. Electrolytes and vitamins are added through the self-sealing rubber cap, as per the physician's order. According to the author, solutions may be prepared one or two days in advance and stored in a refrigerator. In one of the methods used by the Presbyterian-St. Luke's Hospital(1), 250 ml. of protein hydrolysate, 5% dextrose solution is poured off from each of three 1000 ml. bottles. To each bottle is added 350 ml. of 50% dextrose. The total of the three bottles, 3300 ml., contains 13.5 Gm. of nitrogen and 2560 calories—a nitrogen to calorie ratio of 1:190.

At St. John's Hospital in Cleveland(9), solutions are cold sterilized by means of Millipore membrane filtration.

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At. St. Luke's Hospital in Cleveland(10), dextrose powder is dissolved in Aminosol solution 5% and sterilized from a pressurized tank through various grades of Millipore filter membranes. The solution is then packaged in 1000 ml. bottles and sealed with Abbott's Add-N-Seal caps. The procedure is carried out in a laminar air-flow hood to provide a sterile field. The pharmacy at the Hospital of the University of Pennsylvania prepares their solutions using the large volume sterilization method as well as the small volume pour-off and add method(4,8). Their basic nutrient solution, composed of 20% dextrose and 5% fibrin hydrolysate (Aminosol) contains 1000 calories and 6 Gm. of nitrogen per liter.

At our hospital, we have worked mostly with the vacuum system (sometimes referred to as the closed system). In the preparation of these solutions, it is advisable to work under a laminar flow hood no matter what system is used. Sterile concentrated solutions of common electrolyte additives should be on hand. The procedure in use at our hospital is as follows. After calculating the amount of protein solution and dextrose needed per bottle, the excess protein solution is poured out of each liter bottle into a large graduate under the laminar flow hood and discarded. An intravenous administration set is then plugged into a 500 ml. bottle of 50% dextrose solution and allowed to drip into the partially filled protein solution bottle. To do this with a vacuum bottle, the protein solution bottle must be vented from the top of the upright bottle; otherwise, as the inside air becomes displaced by the incoming dextrose solution, the air will seek to escape by forcing the solution which is already in the bottle up the vent tube and out through the top of the bottle. This is done by inserting an 18 G. needle through the triangle site on the rubber closure.

After allowing the desired amount of 50% dextrose to drip into the protein solution, the other required drugs are added. A multivitamin preparation containing vitamins A, D, and E in water soluble form (MVI) is usually requested to be added to the solution. We seal our Baxter bottles with the Baxter 28mm additive cap which is available in individual sterile packages. With McGaw bottles, we use their 36mm plastic dust cap which is sealed to the bottle by wrapping the edge with autoclave tape. Of course the non-vacuum or "open" system is the most time-saving and easiest to work with. This type bottle can be sealed by placing a celon band around the neck and allowing it to dry. These seals are much less expensive than the types mentioned above. After sealing our bottles, they are inspected for particles and labeled with a special Intravenous Additive Service label and given a 24 hour expiration. The label contains all the information about the solution that the physician may be interested in knowing such as total electrolyte content and total calories. Labels for orders that are standardized for a long period of time are processed on an IBM Multiple Type Selectric Typewriter (MTST) to avoid repetition in typing and to reduce chances of typing errors.

One interesting item available is a hyperalimentation kit manufactured by McGaw Laboratories. This kit consists of one 500 ml. bottle of 10% Hyprotigen, one 1000 ml. bottle containing 500 ml. of dextrose 50%, one transfer set, one additive cap, and one pressure sensitive label. The half-filled liter bottle of dextrose has a high vacuum which can draw the contents of the 10% Hyprotigen bottle in less than a minute. One slight disadvantage in using this kit is that it might be difficult to prepare certain ratios of dextrose to protein solution without breaking the vacuum. Another item which could be of some use to pharmacists in preparing these solutions is the Baxter crimping tool. (43 mm code no. 2A8890) The approximate cost is $12.00 and it can be used to seal the Vacuum Plasma Collection Unit, Empty (cat. no. 2A 85-06).

For the hospital pharmacist who may not be in a position to offer complete intravenous additive service to his hospital, the preparation of these solutions by the pharmacy can serve as an important first step in an anticipated program. This type of service is well accepted by physicians and nurses and provides a practical method of demonstrating to the staff and to administrtaion, the pharmacist's capabilities in this area.

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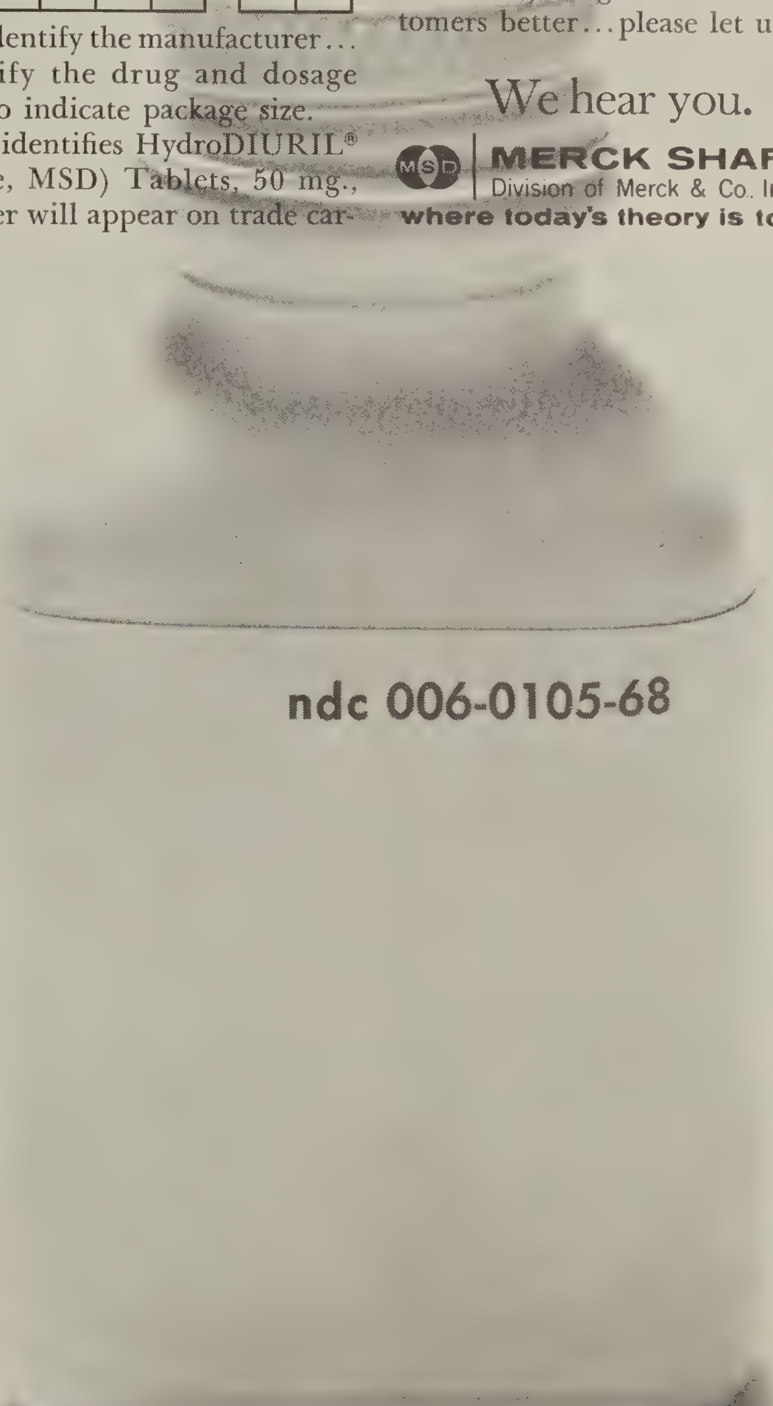


Maryland Society of Hospital Pharmacists Meeting of October 8, 1970

The October 8 meeting was held at St. Joseph's Hospital in Baltimore. Mr. Vince Trovati, Product Service Coordinator, Professional Services Department, Roche Laboratories, gave an interesting presentation on Parkinson's Disease and the use of levodopa.

June Shaw reported that Dr. Dean Levitt would be our next meeting's speaker at the US Public Health Service Hospital. The December meeting was set for Greater Baltimore Medical Center and the January meeting at Mercy Hospital.

Normand Pelissier reported on the MPhA membership drive. The following new members were approved. Charles Myers (Baltimore City Hospital), Morris J. Alliker (Eastpoint Medical Center), Salvitore LaVerde (Good Samaritan Hosp.), Alan Jaskulski (St. Joseph's Hosp.), Ronald Iwicki (Upjohn), Ingrid Baramki (GBMC), and Andrew Glorioso (Class of '72).

Steve Cohen will present a paper at the mid-year clinical meeting in Anaheim in December. Bob Snyder thanked Sr. St. Henry for hosting the meeting and Roche Laboratories for sponsoring the meeting. The meeting adjourned at 9:35 P.M. A tour of the new satellite pharmacy was arranged after the meeting.

Maryland Society of Hospital Pharmacists Meeting of November 12, 1970

The November 12 meeting was held at the Officer's Club of the U. S. Public Health Service Hospital in Baltimore. The evening's speaker was Dr. Dean Levitt, Associate Professor and Chairman of the Department of Pharmacy Administration at the University of Maryland School of Pharmacy. In his talk, which was entitled "Economics of Hospital Pharmacy," Dr. Levitt stressed the need for hospital pharmacists to know the costs involved with each aspect of their pharmacy operation.

June Shaw reported that the December meeting which will be held at Greater Baltimore Medical Center, will have Dr. Eugene Riley as guest speaker. A joint meeting with the D. C. Society of Hospital Pharmacists is proposed for April 15.

Nathan Gruz announced that Diabetes Detection Week is November 15th to 21 and asked for volunteers to man the detection booths at the different armories. Delegates were elected to the Annual Meeting of the ASHP to be held in March, 1971 in San Francisco. The three delegates elected were Robert Snyder, Sydney Burgee and Mary Connelly. Elected alternates were Thomas Patrick, Carroll Paulick and George Jones. The names of the following new members were read and approved. Harold Williams (Eaton), Gayle E. Morgan (U. of Md. Hospital), John D. Morgan (USPHS), Steve Hilbert (Class of '71) and Thomas Kearney (Class of '71).

Nathan Gruz announced that the MPhA had officially voted to affiliate with APhA. The mail ballot was 220 to 35 in the affirmative. Bob Snyder thanked Kent Johnson of the USPHS for hosting the meeting and Loewy Drug for sponsoring the meeting. The meeting adjourned at 9:45 P.M.

Regional Science Fair Award Winners

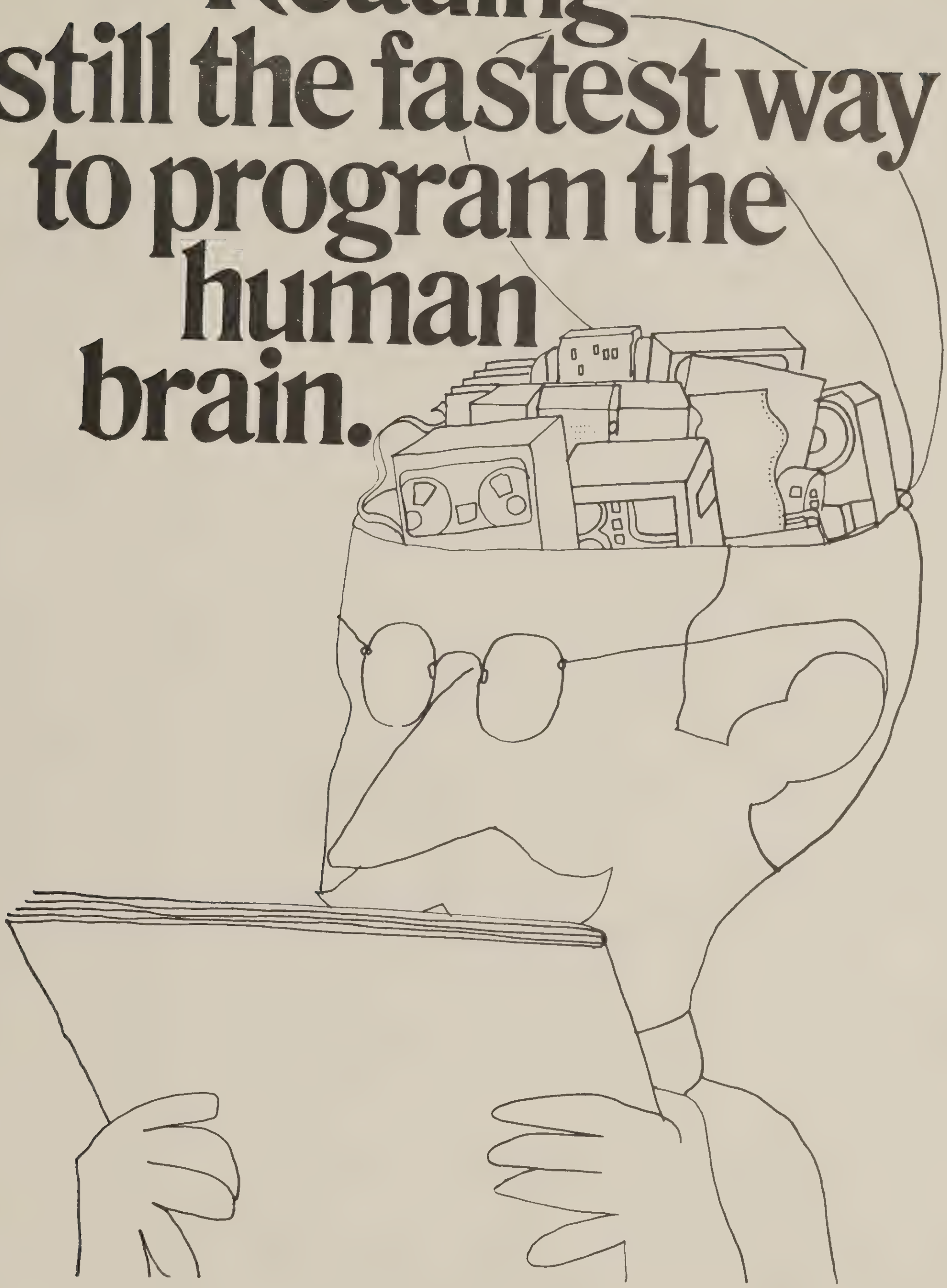
Photo by District Photo

Photo by Paramount Photo Service

The Prince George's-Montgomery County Pharmaceutical Association recently presented a ceramic mortar and pestle to first place students in the Montgomery and Prince George's Counties Regional Science Fair whose projects best depicted the science and profession of Pharmacy.

The Prince George's County winner, Anita Starkey, a Senior at LaPlata High, was selected for her project "Drug Effects on the Turtle Heart." In the photo at top, she is shown receiving her award from pharmacist Samuel Norris. The Montgomery County winner, Eileen Martin, a Senior at Pyle Junior High, was selected for her project, "The Billion Years' War: Microbe vs. Microbe." In the photo at bottom, she is shown receiving her award from pharmacist Edward Nussbaum.

Reading is still the fastest way to program the human brain.



In an era of "information explosion," how do you "program" information to the human brain? Spoken language is far too slow. The average person speaks about 150 words per minute. Fast readers can read up to 1,500 words a minute—ten times the average rate for the spoken word. Perhaps this is why millions of people regularly purchase from pharmacies, magazines, paperbacks, comics and newspapers from insight and enjoyment.

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Early Pharmacy In The Baltimore Campus Area

(University of Maryland)

Part V

by

Benjamin F. Allen

In 1844, the Maryland College of Pharmacy entered into an arrangement with the University of Maryland (at Lombard and Greene Streets) whereby the lectures of the College were to be united with those of the University for the mutual benefit of the students of pharmacy and medicine. This arrangement continued in force until the year 1847, when interest in the pharmacy college began to decline.

In 1882, the faculty of the University secured a charter from the Legislature for a Department of Pharmacy to be added to the School of Medicine. In 1904, the Maryland College of Pharmacy (located on Aisquith Street north of Fayette Street) united with the University of Maryland and became the Department of Pharmacy.

A new Dental Building, erected in 1903-04, occupied the Greene Street side of the University grounds, abutting on Cider Alley. Owing to the size of this building it was able to furnish accommodations also for the new Department of Pharmacy.

The aforementioned structure completed in 1904 replaced the Dental Infirmary and Laboratory Building which had been constructed in 1882 at the southeast corner of Greene Street and Cider Alley (at the time both thoroughfares were cobblestone paved). Today, this former Dental and Pharmaceutical Building is known as 31 South Greene Street, Medical Technology Building, and Cider Alley at this site has practically disappeared from the scene.

In 1904, when the Maryland College of Pharmacy (49 North Aisquith Street) terminated its independent existence and amalgamated with the School of Medicine, the Monumental City witnessed its *Great Fire*. The blaze started on Hopkins Place near Lombard Street, the site today of the Federal Building in Hopkins Plaza.

With the change in organization from that of an independent institution (Maryland College of Pharmacy) to a unit of a University (Department of Pharmacy), the office of president was abolished and a dean was appointed to assume the responsibilities of the principle administrative officer. The first occupant of this position was Charles Caspari, Jr. (Professor of Pharmacy, 1879-1904, The Maryland College of Pharmacy) and he continued in this capacity up to the time of his death in 1917.

Professor Caspari was very active in having the old Pharmacy College become associated with the University of Maryland. In 1902, he was a member of an Executive Committee that took full charge of the College concerning income and the payment of expenses. Early in 1904, the Board of Trustees (Maryland College of Pharmacy) appointed him a member of the committee "to close the connection" with the University.

After the amalgamation with the professional group on Lombard Street (in 1904-05 this included instruction in medicine, law and dentistry with an enrollment of over 800 students), Caspari became a member of the over-all administration of the University.

At this time, the Board of Regents of the University of Maryland consisted of the Provost and nineteen other members. One of these members was Charles Caspari, Jr., Ph. G., Professor of Theoretical and Applied Pharmacy, Dean of the Faculty of Pharmacy.

Pharmacist, educator, organizer and administrator, Charles Caspari, Jr. was born in Baltimore on May 31, 1850, and many of his movements and activities centered within the boundaries of the present University campus or a very short walking distance of it.

He was christened at the Zion Lutheran Church (still in active operation today) which was almost next door to his home, the store of his pharmacist father on the west side of Gay Street north of Fayette Street (in 1841, the Maryland College of Pharmacy opened on Gay Street north of Baltimore Street).

The young Caspari was later a pupil of a Presbyterian Minister at Cathedral and Mulberry Streets, who was noted for his thoroughness and scholarship in general education. Caspari, Jr. also attended the Academic Department of the University of Maryland, but was not graduated therefrom.

Charles Caspari, Jr. grew up in the atmosphere of pharmacy and it was almost natural that he should engage in the profession. In 1865, he was an apprentice in an apothecary shop at Pratt and Howard Streets. His preceptor was Louis Dohme, one of the founders of Sharp and Dohme, now known as Merck, Sharp and Dohme. In 1869, he graduated from the Maryland College of Pharmacy.

Upon the death of his father in 1870, Caspari, Jr. became the proprietor of the drug store on Gay Street. He later conducted a store at 800 West Baltimore Street, northwest corner of Fremont Avenue. The Baltimore Street store was sold by Caspari in 1891.

This building with an empty store front is still standing today. It is also interesting to note that in 1926 this drug store was operated by Stanley Bambach who received the degree of Doctor of Pharmacy on May 13, 1904 from the Maryland College of Pharmacy on Aisquith Street.

Caspari also operated a store at Carey Street and Harlem Avenue. His home address in 1899 was listed as 1129 Harlem Avenue and this typical City of Baltimore large three story rowhouse still stands today. The Harlem Avenue home address is only a short walking distance from the Baltimore Street store location.

In 1905, the Department of Pharmacy was assigned, for laboratory instruction and delivery of lectures, several

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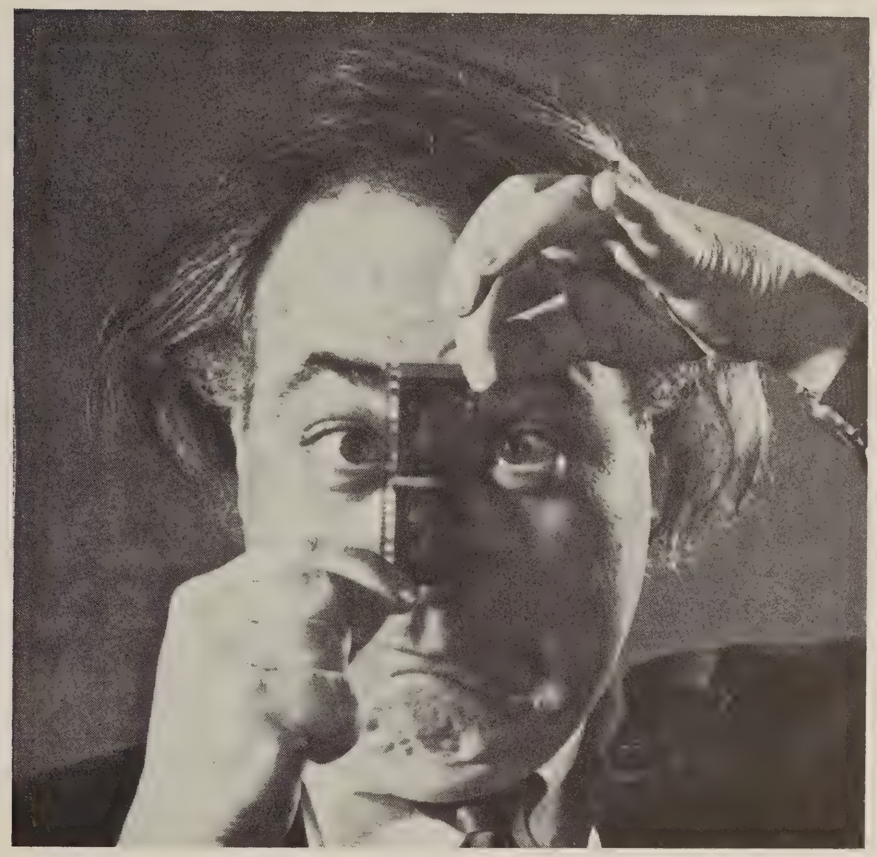
*This is the fifth installment in a series of continuing articles which has been published in this Journal since August 1966. The author is a registered pharmacist in Maryland and Associate Professor of Pharmacy at the University of Maryland.

odd orders processed, naturally



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large, well-lighted and thoroughly-equipped halls in the various University buildings at the northeast corner of Lombard and Greene Streets. The Dean's office was located on the second floor of the new Dental and Pharmaceutic Building recently erected on the southeast corner of Cider Alley and Greene Street. It was not until many years later that the Dean's Office moved to the first floor of this building. (It is interesting to note that today, the word "Pharmaceutic" is widely used in pharmacy circles).

At this time it was also publicized that the University *is easily reached by the electric cars of Towson and Catonsville line, which pass the grounds* (actually the line ran on Lombard Street), *and transfers to which may be obtained from the conductors of all car lines, passing railroad depots, and steamboat landings in the city.*

During the school session 1905-06, in order to give greater stimulus to the study of practical pharmacy it was stated that an appropriate prize would be presented *to that member of the Senior Class who shall make the highest record in both theoretical and practical pharmacy. Formerly this was awarded for laboratory work alone, but it has often happened that a perfect manipulator was very ordinary in theory. Consequently the winner must obtain maximum rating in both areas.*

Information regarding good boarding-houses in the neighborhood of the University could be obtained from the janitor, who furnished applicants with a list, giving location, conveniences and rates (board and lodging $112 to $148 for a session of 32 weeks).

NOTE: Mr. Ross P. Campbell, 2625 N. Calvert St., Baltimore, Md. recently reported that the Caspari Pharmacy on the northwest corner of Baltimore Street and Fremont Avenue was subsequently registered under William A. Stuart and that his son-in-law, Stanley Bambach operated the pharmacy until 1932.

Faculty Promotions and Appointments Announced

Dr. William J. Kinnard, dean of the University of Maryland School of Pharmacy, has announced faculty promotions and appointments at the school for the academic year.

Dr. David A. Blake has been named chairman of the department of pharmacology and toxicology. Three new appointees have joined this department as assistant professors: Dr. David A. Brown, who recently received his degree from Harvard University; Dr. Sharon K. Chapman, a recent graduate of the University of Florida College of Medicine; and Dr. Robert T. Louis-Ferdinand, who was recently associated with the University of Rhode Island.

Henry G. Seidman, instructor in pharmacy, has been appointed director of continuing education programs for the school.

Dr. Karl-Heinz A. Rosler has been appointed assistant professor in the department of pharmacognosy. Dr. Rosler, recently on the faculty of the University of Texas at Austin, received his degree from the Institut fur Pharmazentische Arzneimittellre der Universitat Munchen, and has more than 25 scientific publications in the area of flavenoids and xanthones.

Winifred Sewell has been appointed head of the Drug Information Center, jointly with the School of Pharmacy and the Health Sciences Library of the University of Maryland. Prior to this appointment, Miss Sewell was chief of the Drug Literature Program at the National Library of Medicine in Bethesda.

Helen O. Ross, a graduate of Howard University in Washington, D.C., has been appointed instructor in pharmacy, serving jointly between the School of Pharmacy and University of Maryland Hospital.

David S. Roffman, a 1970 graduate of the school, has been appointed an assistant in pharmacy.

Phi Delta Chi Reorganizes its Alumni Association

Robert Michocki, president of Phi Delta Chi Fraternity, announces that the fraternity is presently reorganizing its alumni association. The school chapter is quite active and publishes a bi-weekly newsletter entitled the "Pill Post." Further information about meetings may be obtained by contacting the chapter president.

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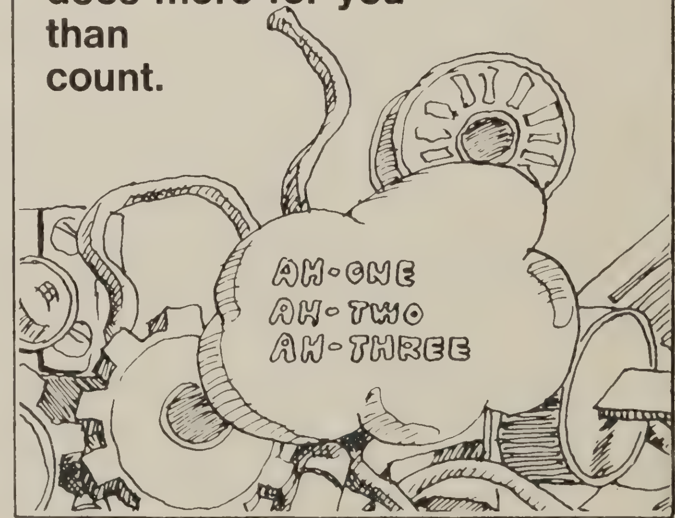

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The Hallucinogens

by Howard Sherman

Staff Pharmacist, Union Memorial Hospital, Baltimore

Few drugs have ever attracted the attention being directed toward the hallucinogens, and none have provoked more controversy. Emerging from relative obscurity, these drugs now present a serious problem and a challenge to both medical science and society.

The hallucinogenic drugs are also called "psychodysleptic," "psychotogenic" and "psychotomimetic" drugs, because of the psychotic-like symptoms which they produce. They also have been termed "psychodelic" (mind manifesting), because they distort or intensify the user's sense perception and lessen his ability to discriminate between fact and fantasy. Vision is most markedly altered, but other senses are also affected. Sensations may "crossover"; that is, music may be seen or color heard. The unpredictability of the effects of hallucinogenic drugs is the greatest danger to users since these effects may range from bliss to horror, sometimes within a single experience. As with stimulants and depressants, the user of hallucinogens may develop psychological dependence upon the drugs; however, physical dependence does not develop.

Marihuana

Marihuana comes from the plant Canabis sativa, more frequently called Canabis indica, or Indian Hemp, or simply hemp. Tetrahydrocanabinol (THC) is believed to be the active ingredient. THC appears in highest concentrations in the flowering tops of the unfertilized female plant, the parts that produce the strongest drug effect. The pure unadulterated resin from this part of the plant is known as hashish (or hash, or charas). The word hashish, incidently, is derived from the same Arabic root that produced the word assassin, indicating the long-standing association of the drug with antisocial behavior. Other plant parts contain smaller proportions of THC and produce less effect. The mind-altering ability of marihuana depends upon potency, and potency varies considerably with plant parts, climate, soil condition, time of harvesting, storage conditions, and methods of preparation. It is not surprising, therefore, to find a tremendous range of response from a poor grade plant material to the potent, pure hashish. Users prefer material from Mexican or Middle East sources to the weak product of the United States.

The mechanism of action of marihuana and THC are not completely understood, and there is little information on the long term effects. Immediaet effects, such as tachycardia; hypothermia; dilatation of pupils; and inflammation of mucosa of the nose, throat, and lungs; are well documented. The major effects are upon the user's mood and ability to think clearly, varying greatly with the quality and quantity used. Response ranges from depression to excitement, often influenced by the social setting, anticipated response, and the individual's psychological make-up. When smoked, the drug effect is felt quickly and may last from 2 to 4 hours. Sudden withdrawal may provoke psychological symptoms such as restlessness and anxiety in heavy users, but there is no evidence of true physical dependence to marihuana.

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4-Methyl-2, 5-Dimethoxy-amphetamine	Chemical Synthesis	STP	—Related to Amphetamines, much more potent. —Dose of 1-3mg. produces euphoria. —Dose of 3mg. or more produces hallucinogenic effects for 8-10 hours.
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Marihuana	See separate discussion above:		

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Maryland Pharmacists In The News

Dean WILLIAM J. KINNARD, U. of Md. School of Pharmacy, has recently been elected to the Board of Directors of the Drug Information Association. THEODORE BENYA, formerly Chief Pharmacist at the University of Maryland Hospital is now studying for his Ph.D. at the University of Michigan. DONALD O. FEDDER, MPhA President, is a candidate for Region I Representative of the APhA Academy of General Practice of Pharmacy. Dr. JOSEPH F. GALLELLI has been appointed Chief of the Pharmacy Department at the National Institutes of Health, Bethesda, Md. GEORGE P. PROVOST, Editor of the American Journal of Hospital Pharmacy has been selected for a National Health Fellowship at the University of Michigan School of Public Health. Assistant editor and MSHP member WILLIAM A. ZELMER will take charge of editorial offices. Results of University of Md. Student APhA-MPhA annual and run-off elections are DARLENE McMAHON, president; DAVID SNYDER, vice president; MARGARET KARSCH, secretary and HARRIET LEE, treasurer. Miss Lee also will head minority recruitment committee working with Howard University in the Baltimore-Washington area. KENT JOHNSON replaces PAUL LeSAGE as Chief of the Pharmacy Department at the USPHS Hospital in Baltimore. Paul LeSage has assumed duties of chief pharmacist at the USPHS Hospital in San Francisco.

Burglars Most Often Choose Windows

Windows are the weakest point in a store's security according to S. J. Curtis, former head of Security of Lord & Taylor. Retail stores are reeling under the impact of burglary losses. Each day, 5000 more stores are broken into, adding up to 1.8 million reported burglaries each year costing more than $500 million. Never before has security been so important to the proprietor. No system, however, is unbeatable. The purpose of security is to build obstacles to delay the average thief and convince the sophisticated one that gain is not worth his effort and risk.

Where are the weak points in a locked store? From analysis of several thousand cases, a scale of frequencies has been determined for break-ins:

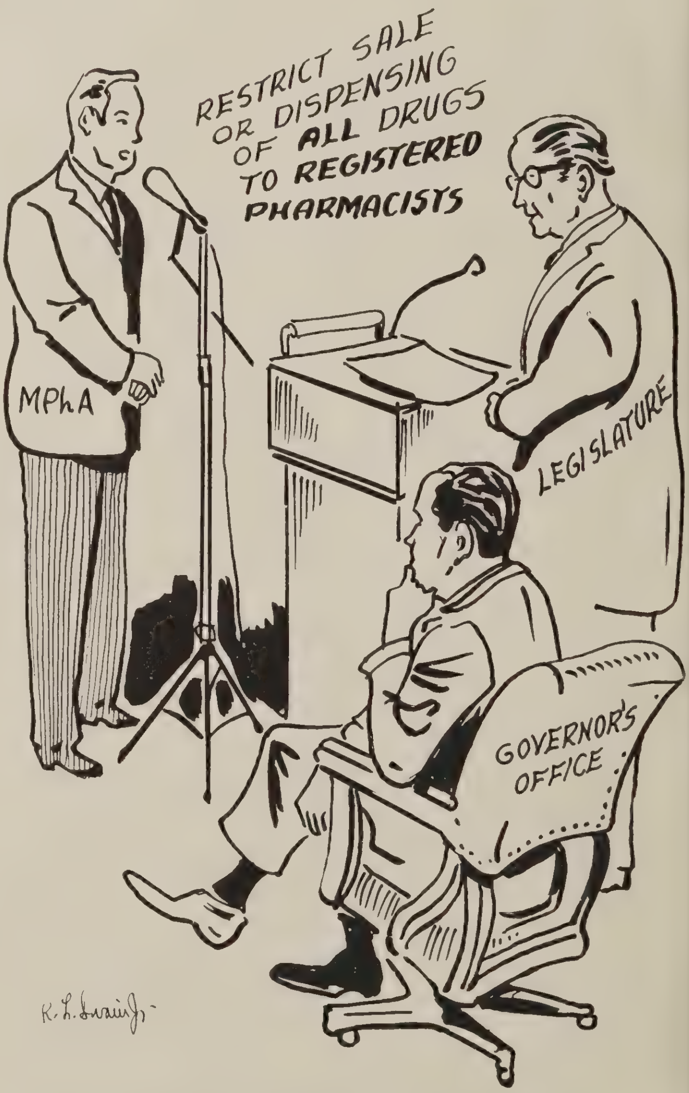
—Front windows, 22%
—Glass in front door, 16%
—Rear or side window, 14%
—Forced rear door lock, 13%
—Glass in rear door, 10%
—Forced front door lock, 9%
—Roof or skylight, 2%
—All other sources, 14%

Knowing where your vulnerable points are, you can strengthen them. Burglar-resistant glass should be used in all display windows and exterior doors; it has high tensile strength with a sheet of invisible plastic compressed between two sheets of glass that can be broken only by continual hammering with a heavy instrument. Avoid small panes of glass set in steel frames, as the metal is not strong enough to resist forced entry. Unless a window is needed for ventilation, glass brick should be used. Windows should be secured on the inside with bolt, slide bar or crossbar and the frame should be securely fastened to the building. The pins on the hinges should be welded or flanged. In high-risk areas, show windows should be protected with heavy metal screens or grating.

Metal foil on windows is not too desirable. The tapefoil or wire is easily broken, causing false alarms and costly maintenance, and experienced burglars can defeat it by bridging the foil. Intrusion switches on doors and windows should be a simple magnetic switch. Metal contains rust and rain can cause false alarms.

Security can be built into a new store at little or no additional cost, if considered prior to construction during the period of design. In fact, cost per square foot for similar buildings is about the same whether they are built for maximum security or are as flimsy as wet tissue paper. Good store security design is like common sense: the knack of seeing things as they are and doing things as they ought to be.

Adapted from *Chain Store Age,* June 1970.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Swain Pharmacy Seminar

FEBRUARY 11, 1971

(See Page 19)

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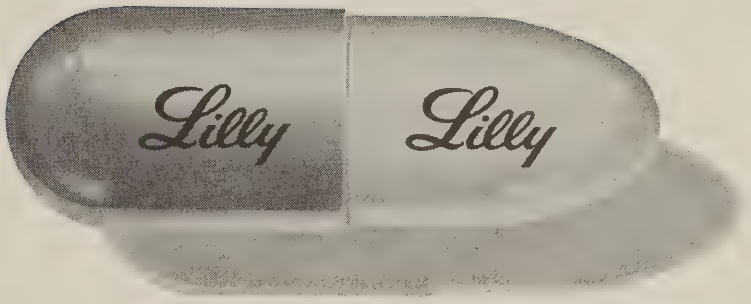

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Editorial . . .

Priority One For Pharmacy—
Third Party Payment Plans

"Third party payment" health programs vitally affect every pharmacist regardless of the facet in the profession which he occupies. This is "Priority One" for pharmacy. The outcome of the struggle which will become more intense in the coming months will determine the nature of our health delivery system and who will have input into decision making. Our internal unity and strength may be the critical factor to determine the fate of pharmacy in this strategic battle.

We are using the term "third party payment health programs" to cover both the governmental and private sectors of our society. This means Medicare, Medicaid, Blue Cross, various union health plans, private insurance company plans, as well as plans for national health insurance.

In order to make sure that the pharmaceutical services of the highest standards are always provided, we in pharmacy must develop the means to accomplish the following:

1) Formulate a definition of pharmacy services for the 1970's
2) Prepare guidelines as to standards for these services
3) Institute a mechanism of peer review and meaningful self-discipline to assure compliance with these standards
4) Establish the kind of research, survey and analysis capability needed so that we can maintain a constant up-to-date flow of professional, socio-economic and financial data to substantiate appropriate compensation for services
5) Innovate proposals to meet the overall unmet health needs of the country, but particularly directed to the quality of pharmaceutical services—deficient in certain urban and rural areas as well as in many medical institutions such as extended care facilities, nursing homes and the numerous hospitals who have no pharmacists.

Let there be no mistake about this matter at this time. If pharmacy does not come up with solid data and plans about pharmaceutical services, about how they should be provided and about their costs and charges, then others in and out of government appear more than anxious to do so.

With proposals for some plan for financing national health insurance, or instituting a comprehensive health care delivery system proliferating daily, prudent observers can recognize the political realities. We can expect enactment of some kind of national legislation along these lines within one to three years.

The time for a merely "count and pour" practice of pharmacy is past. Let us initiate, not merely react to the ideas, proposals and legislative bills introduced at the behest of other health and non-health connected groups.

The year 1971 may well be the year of decision for pharmacy as a free independent profession.

—Nathan I. Gruz

John Crozier Testimonial February 18, 1971

Executive Changes at Calvert Drug Company

John A. Crozier, Executive Vice President and General Manager of the Calvert Drug Company for 32 years, announced his retirement effective December 31, 1970. He had been with the firm for 44 years.

Mr. Crozier is being tendered a testimonial dinner at Blue Crest North, Pikesville, on Thursday, February 18, 1971.

He has been active in every project of the profession of pharmacy and has been recognized for his many contributors to the welfare and survival of the free practice of pharmacy.

Mr. Crozier was a past president of the Baltimore Drug Exchange and the Traveler's Auxiliary of the Maryland Pharmaceutical Association (TAMPA). He has been recognized for his contributions to the advancement of Pharmacy by his election as Honorary President of the Baltimore Metropolitan Pharmaceutical Association in 1964.

All pharmacists and all those associated with the drug industry are invited to attend on February 18 to honor John Crozier.

The Board of Directors of Calvert Drug Company promoted Joseph J. Hugg to succeed Mr. Crozier as Executive Vice President and General Manager and C. Wilson Spilker to Vice President and Assistant Manager. John Crozier was appointed a consultant and Board Advisor.

Kenneth L. Mills is now serving as Sales Manager. Phillip Wainwright was named to succeed Ken Mills as representative on the Eastern Shore.

PHARMACY CALENDAR

January 31—Baltimore Metropolitan Pharmaceutical Association Annual Installation Banquet and Dance, Blue Crest North.

February 11—Swain Pharmacy Seminar, Good Samaritan Hospital. Theme—"Pharmacy in the 1970's".

February 11—MSHP monthly meeting, Good Samaritan Hospital.

February 18—John A. Crozier Testimonial Dinner, Blue Crest North, Pikesville.

March 11—Univ. of Md. School of Pharmacy Alumni Association Dinner Meeting, Eudowood Gardens.

March 27-April 2—APhA Annual Meeting, San Francisco, California.

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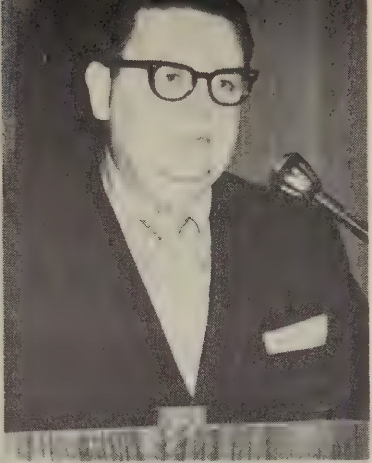

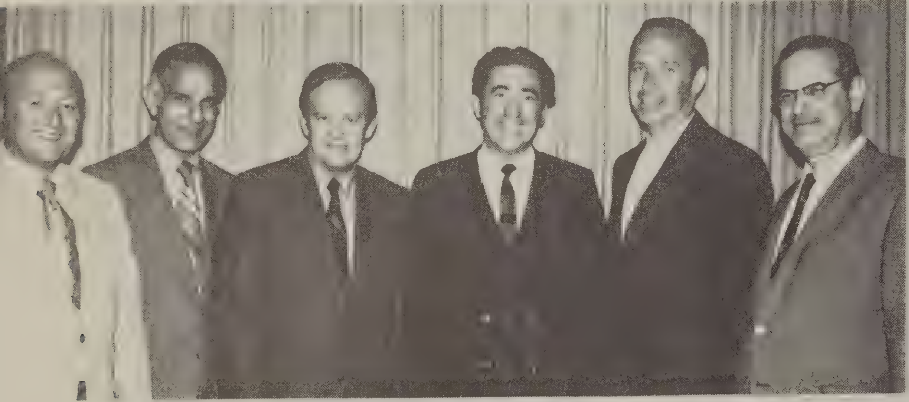

Some Highlights of 1970

(Upper left) PHARMPAC Testimonial Dinner Honors Victor H. Morgenroth, Jr., as president of the American College of Apothecaries. Left to right: Anthony G. Padussis, Mr. Morgenroth, Morris R. Walman, Bernard B. Lachman, all officers of the Pharmacists Political Action Committee.

(Upper right) Arnold L. Amass, Finksburg pharmacist, candidate for State Senate for Carroll-Frederick Counties. MPhA President Fedder was a candidate for House of Delegates in Baltimore County.

(Middle left) Prince Georges Montgomery County Pharmaceutical Association meeting on PHARMPAC and affiliation. Left to right: MPhA President Elect Nathan Schwartz, BMPA President and PHARMPAC Chairman Padussis, PHARMPAC Treasurer Lachman, Prince Georges-Montgomery President Rudolph Winternitz, MPhA President Fedder and local Secretary Paul Reznek.

(Middle right) BMPA Treasurer, Charles E. Spigelmire served as PHARMPAC Toastmaster.

(Lower left) I. Earl Kerpelman 1969-70 MPhA President receives a past president's award from Philip Levin, President of Loewy Drug Company.

(Lower right) Prince Georges-Montgomery County Pharmaceutical presents Certificates of Merit to Secretary Paul Reznek (left) and official photographer Herman Bloom of Paramount Photo Service. President Winternitz (center), presided at annual Scholarship Affair.

LAMPA News

LAMPA'S 1970 Fall Regional Meeting was held at the Chestnut Ridge Country Club, Lutherville, Maryland on Thursday, October 22, 1970.

President Dora Rockman presided at the business meeting and introduced the speakers for our Mini-Craft Day. Reports from our officers relative to our finances and membership were favorable.

It was announced that the 1971 Annual Maryland Pharmaceutical Association Convention would be held in May at the Hunt Valley Country Club in Owings Mills, Maryland. This is a change from the format of previous years and it is hoped this change will enable more pharmacists and their families to attend. A short, post-Convention trip is also in the making. LAMPA is represented on the MPA Convention Committee by Dora Rockman and Anne Crane.

From the members attending, we learned that Mrs. Robert Henderson (Lyn,) perhaps our youngest member, has a brand new son, and that Dorothy Austin became a grandmother for the 7th time. Also, that Mrs. Nathan Schwartz was expecting a call from the hospital telling of the arrival of her first grandchild. (It was a boy, born the next morning.) The business meeting over, the members relaxed and watched Arlene Padussis give the lowdown on professional looking hems; through correct use of the iron and the wooden block.

Since Alberta Neun, party giver par excellence, could not attend, her display of original party favors, most of which were made to fit inside bottle caps, was carefully explained by Dorothy Austin. Of special interest were four favors commemorating Jewish holidays. Also, cleverly presented were favors for wedding and baby showers, birthdays and Christmas.

The next exhibit, possibly a first for local pharmacy, was a colorful display showing various new uses for old pill bottles, vials and boxes. A Christmas tree decorated entirely with dressed-up pill bottles; a pharmacy version of Chinese fortune cookies, a holiday door swag, as well as uses for travel, sewing, gardening, coin collecting and even jewelry soaking were shown. It was conceived and worked-up by Anne Crane. This unique exhibit was featured on the November cover of THE MARYLAND PHARMACIST.

The highlight of our Mini-Craft Day was provided by Margaret Pokorny, making her second appearance on a LAMPA program. She showed us how to make our own pressed flower pictures, which are very much in vogue and expensive. We shared her methods for selecting, pressing and arranging as well as tips on backing and frames. It was just fascinating to see a beautiful object evolve. The group's thanks went to Mary Schrader, Mary DiGristine and Anne Crane for bringing in dry materials and fabric for distribution to our members.

On leaving, each member received a small wood block, to use in future hem projects; a small gold-color frame to house our own pressed flower picture; and Whitman's candy. Door prizes included a homemade cake used in the pill bottle display; two handsome pressed flower pictures, created by Margaret Pokorny, tote bags and make-up mirrors.

Mini-Craft Day was Maxi Fun Day too!

—Anne Crane
LAMPA Communications Secretary

Baltimore Metropolitan Pharmaceutical Association

The Annual Meeting and Election of Officers was held on December 14, 1970. President Anthony G. Padussis presided.

Reports were presented by the President, Treasurer Charles E. Spigelmire and Executive Director Nathan I. Gruz.

Committee reports included: Membership: Paul Freiman; Public Relations: Charles E. Spigelmire; 1970 Banquet: Irvin Kamenetz; 1971 Banquet: Joseph U. Dorsch.

Bernard B. Lachman, Chairman Nominating Committee, reported the slate for officers and executive committee for 1971. The following were elected unanimously:

President: Irvin Kamenetz
President Elect: Joseph U. Dorsch
Vice Presidents: Paul Freiman, Harry R. Wille, Harold P. Levin
Secretary and Executive Director: Nathan I. Gruz
Treasurer: Charles E. Spigelmire

Executive Committee

Chairman: Anthony G. Padussis
Robert W. Henderson (1971)
William I. Lottier (1971)
Ronald Lubman (1972)
John Padousis (1972)
David I. Scott (1971)
Henry Seidman (1971)
Melvin Rubin (1972)
Charles H. Wagner (1971)

Ex-Officio

Mr. Francis S. Balassone
Dr. William J. Kinnard, Jr.

Mr. Byron Millenson, Vice President and General Manager of Radio Station WCAO was elected Honorary President.

George Stiffman, Chairman of the Arrangements Committee, was commended for his devoted efforts during the year.

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Nathan I. Gruz, Editor
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The Pharmacist and Patient Care

by Patrick H. Birmingham,
Director of the Department of Pharmacy and Medical Supply, Good Samaritan Hospital, Baltimore

Presented at the 88th Annual Meeting of the Maryland Pharmaceutical Association, July 14, 1970, Shelburne Hotel, Atlantic City, New Jersey.

The Good Samaritan Hospital is a 285 bed, chronic disease facility located in North East Baltimore. It was built from funds left by Thomas O'Neill, a Baltimore merchant, and opened in November of 1968.

Among hospitals in Maryland, The Good Samaritan is unique in that it provides various levels of care as well as limiting itself to the type of patient that can be accepted for care. The hospital has a full time medical staff made up of physicians with experience in internal and rehabilitory medicine. Each physician has patient care assignments based on the geographical division within the hospital.

While The Good Samaritan Hospital is unique, the Pharmacy Service may be said to be even more unique. Never, in Maryland, or on the East Coast for that matter, have so many areas of responsibility been under the direction of the Pharmacy. The Director of Pharmacy Service is responsible for the entire drug distribution system in the hospital from the selection and procurement of drugs to the actual administration of drugs to the patients. The Pharmacy distributes drugs by the unit-dose method, that is, each dose is individually packaged and labeled with the non-proprietary name of the drug, the trade name, the strength or concentration, the expiration date and the lot number. Each dose is placed in a drawer of a cart labeled with the patient's name. Therefore, under the direction of the Pharmacy, every dose is prepared, labeled, and stored for administration to the patient. Starting on July 13, pharmacy technicians began administering drugs to patients on the nursing units. We are therefore the first hospital on the East Coast to use technicians to administer drugs, as well as prepare doses. Other areas of responsibility include the preparation and administration of intravenous fluids and the selection and distribution of medical and surgical supplies throughout the hospital.

The one outstanding fact I wish to make perfectly clear is that a reliable and efficient drug distribution system is the backbone and foundation of everything we have ever done or have attempted to do. Keeping this in mind, I will now describe the clinical involvement of the pharmacists at The Good Samaritan Hospital from the beginning until today. Our clinical involvement has been rewarding and frustrating, eventful and uneventful, has made us very happy and very sad. In short, it has not been too different from any other experience with people and life.

Our clinical role actually began the day the hospital opened. At that time we were staffed with four staff pharmacists, a director, and an assistant director, and three technicians, as well as a nurse—I.V. therapist. Our primary responsibility in patient care was reviewing the medication orders written by the doctor and speaking at least once with each patient before he left the hospital about his medications. We were also responsible for the self medication program.

If you remember, I mentioned that The Good Samaritan Hospital is unique in that different levels of care are given to patients in the hospital. More intense clinical service is necessary for the more acutely ill patient. It is not that clinical responsibility diminishes with the more chronic patient, but that their condition is generally somewhat stable and they do not have to be seen everyday. But I am really getting ahead of the story now.

In June of 1969 we decided to become even more involved in patient care. Instead of relying only on the chart for our information, we began to go on medical rounds, Kardex rounds, and attend the Therapeutic Team Conference held on the nursing unit.

Since Mr. Ginsberg will give you an in-depth view of what this means in terms of the chronic patient, I will discuss the acutely ill patient. Since the condition of a patient with an acute illness can change on a daily basis, medical rounds are held everyday. The physician, pharmacist, and nurse review the patient's condition and change therapy as necessary. The main responsibility of the pharmacist on these rounds is to make sure any medication prescribed is compatible with the present drug therapy of the patient, and that any orders for narcotics, barbiturates, or other extremely dangerous or controlled drugs are reordered if necessary. The pharmacist may also request laboratory data, such as electrolyte or culture tests, to be done on the patient. On these rounds the physician is not primarily concerned with reviewing all orders written for the patient.

He is mainly concerned with changes in the patient's condition and altering therapy to meet the changed condition. However, at least once a week, Kardex rounds are held. These rounds are of particular interest to the pharmacist since on these rounds the physician is concerned with reviewing all the orders previously written for the patient. The pharmacist must come to these rounds ready to discuss every facet of the patient's drug therapy and with any suggestions or changes that he may have. However, if the pharmacist suggests a change, he must be ready to defend his suggestion with logical reasoning. No one accepts change for the sake of change.

At this point I would like to discuss a myth that some pharmacists believe; that is, that the physician always knows what drug to prescribe, in what dose to prescribe it and tells the patient what results to expect. The physician makes a lot of guesses, and those guesses are usually based on clinical experience and are not always based on fact. The physician does not always guess right, and this is where the pharmacist comes in. For example, we have found some patients were quite nauseated and vomiting, not because of their condition, but because of the drugs they were taking. We, in these cases, try to suggest alternative drugs. In other cases we have discouraged the use of such drugs as Elavil in depressed patients when urinary retention was a problem. If the pharmacist had not discussed the parasympatholytic effects of Elavil with the

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physician in one case, the effects of the Urecholine that was being administered would have been negated.

So, you see, this is how our role has developed to date. We find that we need more and more time on the nursing units to accomplish the new work we find almost daily.

I think, however, one of the greatest compliments paid to our staff was the inclusion of the pharmacist on the cardiac-respiratory arrest team. On this team we are responsible for anticipating the needs of the patient during an arrest and preparing the drugs for administration. We have performed quite successfully on the team to date in that the needed medications are usually placed in the physician's hand within seconds after he asks for them, instead of having a two minute delay while a nurse looks for medication and draws it up in a syringe. A second advantage of having a pharmacist available is that he is able to suggest an alternative to a requested drug if the one asked for is not available. The third advantage is perhaps the most important. That is, the pharmacist is responsible for checking the cardiac arrest cart and has an intimate knowledge of the entire cart. He is able to help immediately if another member of the team is confused about what is in the cart or exactly what is needed.

We have certainly been quite successful to date, and I am sure with the drug administration team now beginning to function we are going to even become more involved in the direct care of the patient.

It is a recognized fact at our institution that no one person can take full and complete responsibility for the care of the patient. Each profession or therapy involved with the patient takes the degree of responsibility for the patient commensurate with their involvement. This type of therapeutic team approach has worked quite successfully at The Good Samaritan. When I questioned a physician on the staff about our therapeutic team his only remark was, "I don't know how I ever practiced medicine without it."

I would say, in relation to community pharmacy, there certainly is a need for the clinical pharmacist. In order to speak intelligently with a physician over a patient's drug therapy, however, the community pharmacist is going to have to do more background work than we do at Good Samaritan.

First, he certainly needs a patient drug history, including allergies, a list of habits (such as smoking and drinking) and other pertinent facts related to the patient's health.

Secondly, there is an obvious need for a current profile of drugs the patient is taking.

There has been much written on the subject of drug histories and patient profiles.

Therefore, by simply beginning in these two areas, the community pharmacist can step into clinical practice.

In closing, I do wish to remind you that pharmacy education is changing drastically. The changes began to take place in 1960 with the initiation of the five year plan and have picked up momentum during the last several years.

I am sure that you realize that the pharmacist is one of the only health professionals who is not trained in the hospital setting. He has even, in some states, been discouraged from fulfilling his extern-intern requirements in a hospital pharmacy.

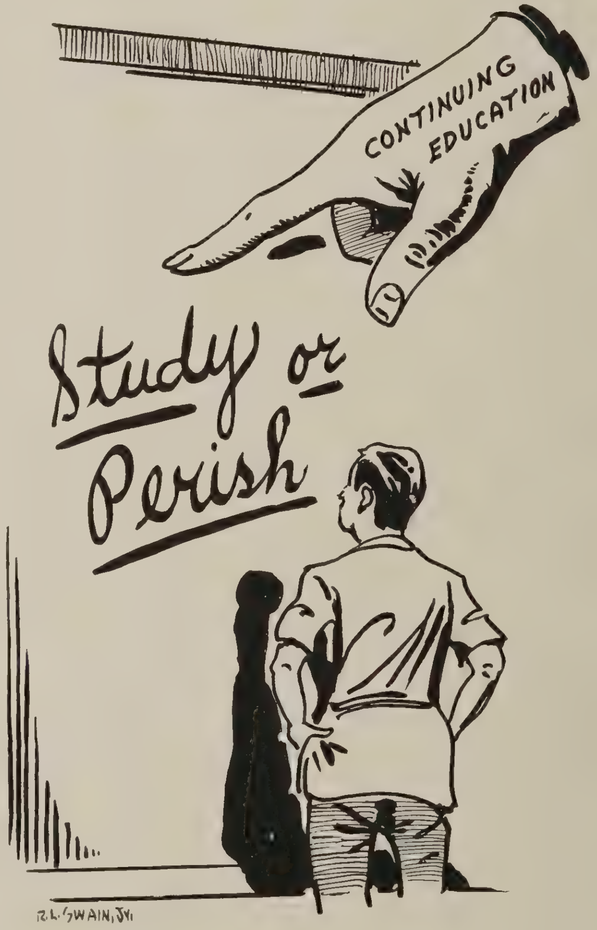
The situation is changing rapidly in Maryland and in other states. The pharmacy student is being exposed to physicians, nurses, and other paramedical personnel with encouraging results in many cases.

It is important to keep in mind that Pharmacy is a growing, dynamic profession, and that we should do all we can to foster new ideas and new approaches to health care, whether in the hospital or in the community.

Hogue Awarded 1970 Roche Hospital Pharmacy Research Grant

Mr. G. Lawrence Hogue, resident of the University of Maryland Hospital, has been awarded the 1970 Roche Hospital Pharmacy Research Grant.

The award, announced by Dr. Peter P. Lamy, Director of Institutional Pharmacy Programs at the University of Maryland was granted for Mr. Hogue's project entitled: "Improving Hospital Out-patient Pharmacy Dispensing Procedures."



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The Clinical Pharmacist on the Chronic Care Unit

by Murray P. Ginsberg,

Formerly Staff Pharmacist, Good Samaritan Hospital,
Baltimore, Now Pharmacy Supervisor, Framingham
Union Hospital, Framingham, Mass.

Presented at the 88th Annual Meeting of the Maryland Pharmaceutical Association, July 14, 1970, Shelburne Hotel, Atlantic City, New Jersey.

In order to fully understand the role of the clinical pharmacist at The Good Samaritan Hospital on a chronic care unit, I believe we should first look at the type of patient one finds on such a unit. The first thing noticed about these patients is that they are more or less veterans of other hospitals. Their experiences in these hospitals have been varied and in many cases horrifying, and now, they are in a new hospital. The next thing one notices is that these patients fall into one of two categories: (1) those patients that can be rehabilitated and (2) those who cannot.

In the first category, for example, may be a patient with a diabetic problem. The patient needs help in order to understand and control his diabetes with diet, drugs, and if need be, physical therapy. The second type of patient includes those with a non-rehability disease—an aged person who has had one or more strokes. In many cases, the old come to us with many problems besides their primary diagnosis.

Medicine, with all of its innovations, has not really taught us how to treat sick, aged people. However, even with medical advancements that prolong life, the social ills of the old sometimes overwhelm any medical problem. Where does the pharmacist fit into this? Why must he get involved in a patient's social problem? The answer is simple. A patient's medical problem and social problems are interdependent. The solution of one is intertwined with, and may provide, the solution to the other. Using these remarks as an outline of the situation in which the clinical pharmacist on the chronic care unit works, I would like to proceed with a description of the development and present status of the role of the clinical pharmacist.

One of the first steps taken in setting up a clinical program is the participation of the pharmacist in medical rounds on his nursing unit. I should mention at this time that each staff pharmacist is presently assigned to one nursing unit. Each nursing unit has a capacity of thirty-six beds, except the acute care unit, which has a capacity of twenty-four beds. One of the first problems realized by the pharmacist was the need for some sort of patient drug profile on clinical rounds. In an institution such as ours, in which the average length of a patient's hospitalization can reach two months, the number of drug orders can be quite high. On rounds, in order to provide the physician with a quick up-to-date look at the patient's drug therapy, a handbook was developed by the members of the staff. The handbook consists of a 5 inch by 8 inch looseleaf notebook. The pages contained space for the patient's name, age, sex, race, location, diagnosis, drug allergies, treatments, prn. drug orders, stat drug orders, and regimen drug orders. The use of such a handbook has provided us with a quick and easy means of analyzing the patient's drug therapy.

Another one of the problems encountered on medical rounds was that of language. Every profession in the world has terms, abbreviations, and/or slang which are unique to that profession. Such is the case with what I would like to term nursing unit language. For example, a nurse's quick summary of a patient's diagnosis might be, "a recent CVA with a right hemi." Or, a physician might ask you if 5 million units of aqueous penicillin is the correct dose for S.B.E. In both of these cases, my first reaction was to try not to look stupid. After several incidents such as these, it became apparent that a language barrier existed. Members of the pharmacy staff attempted to solve this problem by compiling a list of the most commonly used medical abbreviations and their meanings. Although this list has been helpful in solving the communication problem, there still exists to some extent a communication lag. In the main, I have found that the best, however, the slowest, means of solving this problem is simply to admit one's lack of knowledge. Personally, I have found that anyone on the nursing unit is ready to answer any question put to them in an honest attempt to learn.

Another problem we faced was a complete lack of knowledge of clinical laboratory values. In order to effectively advise a physician that drug "X" has, as a normal side-effect, elevated a patient's BUN, we must not only know what BUN is, but what the normal value and what fluctuation above or below this norm means. Again, members of the staff responded by compiling a list of the most commonly used laboratory values. However, as above, we have had to undergo a long and tedious learning period which, at best, has given us a very basic knowledge of the facts involved with a good chance of finding an answer rather than a question.

A fourth and somewhat more difficult problem to solve is that of the physician-pharmacist relationship. If our role as clinical pharmacists was new and somewhat unbounded by definition, one must accept the fact that there must also have been some confusion on the physician's part as to our role. In the past, a physician has held a somewhat distant relationship to the pharmacist. Now, if our roles as clinical pharmacists were to succeed, we would have to establish a close professional rapport with the physician. I would like to stop here and define exactly what I mean by professional rapport, because I feel that this definition has guided whatever success I have had on the nursing unit. It does not necessarily mean becoming good buddies with the physician, although a friendly relationship does help. It does not mean establishing the physician on a pedestal and giving yourself a somewhat inferior role. My belief is that it does mean realizing your limitations and the physicians. Finally, it does mean putting yourselves in the role of members of a team.

Physicians, like most working people, have spent some time in their profession and have a tendency to become set in their ways. Changing these beliefs becomes similar to an ant moving an oak tree. On the one hand, as the physician might see it, we have a medical practitioner with many years of clinical experience, and that whipper-snapper pharmacist is going to tell the physician all about drugs. The pharmacist, on the other hand, believing the physician to have avery small knowledge about a very small number of drugs, is going to tell him all about drugs. Needless to say, both of these viewpoints are extreme. I have found that to make any progress, the physician and pharmacist must work together with a common knowledge of their limitations.

Using the above guidelines as a framework with which to work has provided the pharmacist with the opportunity to make the drug therapy the safest and most effective available.

I think we should also be cognizant of the fact that the pharmacist must also have a close working relationship with the nursing service on his floor. The nurse, more than anyone in the hospital environs, spends more time with the patient and is therefore better able to observe and note changes in his condition. In many cases, a good nurse can spot the early symptoms of a condition which, if left un-noticed, may develop into a life threatening situation. We have noticed that the nurse is a somewhat untapped cource of knowledge of patients' drug reactions. The nurse has also been found to be f great value in evaluating the effect of drug therapy, the incidence of side-effeits, and the relative need for the continuance of a drug therapy. Since we will never have a pharmacist on the floor twenty-four hours a day, the realization must come about that we have a highly trained professional who can be of great service to pharmacy and the patient.

The second area of responsibility of the clinical pharmacist is participation in the therapeutic team meetings. The therapeutic team concept at The Good Samaritan Hospital, as established by Dr. John C. Harvey, the Medical Director, promotes a teamwork atmosphere in the rehabilitory process. The therapeutic team meetings are an example of this. These meetings, held on a weekly basis, are attended by every member of the hospital staff that has after the patient is admitted to the hospital, he is reviewed anything to do with the rehabilitaion of the patient. Soon by the members of this team as to potential for rehabilitation and the method that will be used to see the patient reaches that potenial.

Here again, the pharmacist ran into communication problems. This time, however, it was not only with the medical department but also with the social service department, speech and hearing, physical therapy, occupational therapy, dietary, and so on. Each one of these departments has terms it uses which are unique to that area. In order to fully understand a patient's progress, or lack of it, and the reason why, one must be able to at least have a working understanding of those terms. Even terms and language, I have found, are not as important as knowing how each one of these departments works and what it has to offer. Again we have had to spend more time asking questions and learning than contributing perhaps as much as we wanted. Again, in all cases, members of the hospital staff have been most cordial in taking of their time to answer any questions which a member of the pharmacy staff may have. Only after some time was the pharmacist, through his personal conversations with members of other departments and through his actions at the therapeutic team meeting, taking a more active role.

At first, this role consisted of a listening, non-contributory phase, in which I did not fully gnow what was happening. After sometime I began, as a regular part of the meetings, to brieby go over the patient's drug therapy and relate any drug problems and possible solutions to those problems. For example, in discussing a patient's loss of hearing of high frequency sounds, it was found to be due to previous antibiotic therapy. This discovery was credited to close cooperation and dialogue between the departments concerned. This type of knowledge and cooperation can only lead to a more effective rehabilitory program.

While these meetings and the interdepartmental contact and cooperation have been successful in bringing about a more progressive rehabilitory program, I have come to realize the fact that there is still much that has to be learned. This must include a more extensive understanding of each and every department within the hospital's rehabilitory program. As I have stated previously, this knowledge has served to make our efforts much more effective. However, after a while, it becomes very frustrating when realizing how far we have come, one sits at these meetings and realizes how far we have to go.

I should like to mention here one's duties on a chronic care unit cannot consist of only rounds and team meetings. When it was determined which nursing unit each pharmacist would be assigned, my first act was to introduce myself to the unit nurse co-ordinator or head nurse on that unit. I also asked that any problem concerning drugs or pharmacy be referred to me. After a short while, it became apparent to me that in order to become a more effective part of the nursing unit, I would have to find out what a nurse does. So I approached one of the nurses on the unit and asked her if she would not mind me just following her around for an hour or so once a week for several weeks. The results, I believe, were very interesting for both the nursing staff and myself. The nursing staff, I hope, found that I desired to become an integral part of the working personnel on the floor. As for myself, it increased my respect for nursing a great deal after seeing them perform well the many tasks they have. In other words, I never realized nurses had so much to do and so little time in which to do it. Beyond following a nurse around the unit, I tried to spend as much time as possible on the nursing unit. Much of the time was, and is still, spent familiarizing myself with patient charts, learning about certain procedures, and in general becoming as much a part of the nursing unit as possible. The success of this strategy was shown by the fact that after a while questions and various other problems were funnelled my way; and, strangely enough, I was able to come up with some answers.

Another responsibility of the clinical pharmacist is his role in education. This not only entails education of doctors but of the nursing staff and of patients. On many occasions we have been called on by members of the nursing staff to lecture on drugs. These occasions are looked forward to and are a rewarding experience to all parties concerned. The education of patients on the chronic care unit takes on a different aspect. Patients within the hospital, who are sufficiently able, are allowed to take their own medication. This is generally done to make sure that the patient has enough knowledge to properly administer medication to himself when he leaves the hospital environs. The decision to allow a patient to self-medicate is made by the doctor, nurse, and pharmacist. After this decision is reached, pharmacy prepares all of the patient's regimen medication in multi-dose vials containing a one week's supply of medication. The pharmacist then, by reading the patient's chart and consulting with the nursing staff, becomes as knowledgeable as possible with the patient's history. He then approaches the patient and explains how he is to properly take his medicine and what side-effects can be expected. The nurse still has the responsibility of checking on the patient at each administration time to make sure that he takes his medicine. The pharmacist returns once a week to resupply the patient and audit the patient's medication supply. It is hoped that this in-hospital self-medication gives the patient a somewhat more profound understanding of how he is to properly take his medications and why.

Considering the fact that we have been very successful in our clinical program, the question arises, "Where do we go from here?" The answer is found in an old Chinese proverb, "A journey of a thousand miles begins with one step." There are two basic reasons for this. First, progress has been slow because generally we were not educationally equipped to handle a clinical role. Because of this, too much of our time has been spent in asking questions and learning. In particular, I have found on the chronic care unit that to be an effective contributor there is much that one must learn about the chronically ill patient and about rehabilitory medicine. As I have tried to show, the chronically ill patient requires in many ways a different type of therapeutic aim. Establishing and realizing this aim becomes a very real, difficult, and too many times, an insoluble problem. Secondly, there are many barriers left to be removed. Although our relationship with the physicians in the hospital has resulted in much progress, there is still so much more we can contribute to reach our objective of an effective and safe drug therapy.

Getting a physician to realize this and the fact that we are there to work with him in treating the patient has been a slow and tedious affair. However, we are prepared for a long siege in order to reach our objective of a team effort which affords the patient with the safest and most effective drug therapy possible.

NABP Plans Directory – Possibility of Two Systems Being Developed

The National Association of Boards of Pharmacy has announced that it will soon make available a *Directory of Licensed Pharmacies* in the United States. This *Directory* will assist in the protection of public health; its use will assure that drug shipments go to legal pharmacy outlets. The *Directory* will be restricted in its use and made available only to manufacturers and organizations who have legitimate need for the information. Plans include a State Directory for each Board as well as frequent updating of the *Directory.* All outlets licensed by state Boards of Pharmacy will be assigned identification numbers according to *Green Sheet.*

The National Pharmacy Insurance Council is also developing a similar code and plans to notify every U.S. pharmacy of its "universal" number by mail by the end of December, 1970. NABP plans to issue its numbers by January, 1971.

Swain Pharmacy Seminar

February 11, 1971

The 11th Annual Pharmacy Seminar of the Maryland Pharmaceutical Association will be co-sponsored by the Maryland Society of Hospital Pharmacists on Thursday, February 11, 1971. The theme is "Pharmacy in the 1970's."

The program will be held at the Good Samaritan Hospital, Loch Raven Boulevard and Belvedere Avenue in Baltimore, beginning at 1:00 P.M. Mrs. Roger Andersen of Wilmington, Delaware, will speak on the practice of "clinical pharmacy" in the community setting.

A panel on "Effective Communications Inter- and Intra-Professionally" includes a community pharmacist, a hospital pharmacist, a physician, a dentist, and a nurse, with a pharmaceutical educator as moderator.

Joseph A. Higgins, Director of the Drug Task Force, Special Security Administration will speak on "Factors on Administration of an Out of Hospital Medicare Drug Program."

A social hour at 5:00 P.M. will be followed by dinner at 6:00 P.M. with Dr. Zolt H. Koppanyi of the Baltimore City Hospitals speaking on "The Role of the Pharmacist in Preventive Medicine."

A tour of the Good Samaritan Hospital, which has an extensive Clinical Pharmacy program with pharmacists on the floors and making rounds, will follow.

A short business meeting of the MSHP will be held at 9:00 P.M. to conclude the agenda.

Mrs. June Shaw is Seminar Chairman. Other committee members include: Paul Freiman, Samuel Lichter, Adrian Moscati, Melvin Rubin, Ursula Heyer, Henry Seidman, John Bringenberg, William Hodges and Nathan I. Gruz.

Increase in Average Prescription Price Misleading

Although the price of the average prescription has climbed from $3.22 to $3.86 in the last 10 years, a recent Bureau of Labor Statistics (BLS) study showed that average prescription prices adjusted for the number of doses declined 5.8 per cent. A prescription package costs more today because it contains an increased number of doses according to Dr. John M. Firestone, economics professor at the City College of New York.

Prescription medicine prices have dipped 8 to 10 per cent since 1960 while the number of doses per package has increased 27 per cent. "Although the total national prescription drug bill has been rising steadily in the United States, it has been rising because of greater usage —not higher prescription drug prices," Firestone said.

Firestone said his study was done as a followup to the BLS indexes on drugs. His study showed that average prescription prices adjusted for the number of doses declined 5.8 per cent, retail drug prices declined 9.2 per cent since 1961 and wholesale drug prices declined 7.7 per cent. Firestone served as consultant to the BLS in New York until 1964.

The average prescription that cost $3.22 in 1960 would have cost only $3.03 in 1969 for the same number of doses. If drug prices had remained unchanged over the past two decades, the national drug bill would be at least 20 per cent higher than it is today.

How to Cooperate With BNDD

The Bueau of Narcotics and Dangerous Drugs has specified the steps to be taken by pharmacists when they are requested to cooperate with BNDD agents.

The procedure was outlined by Andrew C. Tartaglino, BNDD Assistant Director for Enforcement, in a letter to APhA Legal Division Director Carl Roberts, who commended BNDD on its prompt efforts to establish the procedure.

"In a recent letter to state pharmacy boards and associations," Mr. Tartaglino wrote, "you alerted pharmacists to protect themselves when cooperating with law enforcement agencies by first notifying both the state board of pharmacy and the state pharmaceutical association in writing. This procedure poses a potential problem for the BNDD in that time is frequently of the essence when a pharmacist's cooperation is solicited. In addition, our investigations are often of a highly sensitive nature requiring that disclosure be limited to those with 'a need to know.'

"While there has never been an instance to our knowledge where the cooperation of a pharmacist has subsequently been denied by BNDD, we fully understand your desire to protect the pharmacist. This can be adequately accomplished in any instance where the pharmacist desires to check the validity of a request by a BNDD agent for cooperation through a telephone call by the pharmacist to the nearest Bureau regional office.

"Telephone confirmation of the request for cooperation can be followed up by a letter from the Regional Director where the cooperating pharmacist so requests. The cooperating activity should proceed upon telephone confirmation unless time permits a delay until arrival of the letter."

Baltimore City Rubella Immunization Program

The city-wide rubella campaign began a year ago when 88,000 children received the vaccine in the city's public and parochial schools. In addition to these youngsters, some 15,000 other children, mostly preschoolers, have been protected in the city clinics or by their private physicians, making a total of 103,000 children protected. Since the city child population in the 1-12 year age group comprises about 180,000 children, a remainder of 77,000 children have yet to be reached in the campaign.

The Baltimore City Health Department was scheduled to begin on November 30, immunization of children unprotected against German measles (rubella) in Baltimore's 145 licensed day nurseries with an enrollment of 5,701 preschool children. In addition, the school immunization program at the kindergarten level will be renewed early in 1971. The Department with the assistance of other governmental and voluntary agencies working in the community will seek to have all other unprotected children vaccinated.

Rubella vaccine is now available at all City Health Department well baby and inoculation clinics, the five comprehensive pediatric clinics and from private physicians.

The importance of preventing German measles now cannot be overemphasized. If a mother gets this disease in early pregnancy, her child may be born blind, deaf or mentally retarded. Moreover, every young girl inoculated now will be protected against the possibility of having rubella later on in the childbearing years.

Maryland Society of Hospital Pharmacists Meeting of December 10, 1970

The December 10 meeting of the Maryland Society of Hospital Pharmacists was held at the Greater Baltimore Medical Center. The meeting was conducted by President-Elect Mary Connelly in the absence of President Robert Snyder. Miss Connelly introduced the speaker for the evening, Dr. Eugene Riley, Emergency Room Physician at St. Joseph's Hospital. Dr. Riley spoke on some of the problems faced by emergency rooms in today's hospitals.

June Shaw reported that next month's meeting would be held January 14, at Mercy Hospital with a dinner starting at 6 P.M. The scheduled speaker was Dr. Joseph A. Mead, Chief of Ambulatory Services and Acting Chief of Medicine at Mercy Hospital. The title of his speech was "New Concepts in Ambulatory Care."

The February meeting will be a combined meeting with the Maryland Pharmaceutical Association in conjunction with the Swain Pharmacy Seminar and will be held at Good Samaritan Hospital on February 11. The theme of the Swain Pharmacy Seminar is "Pharmacy in the 70's."

Mary Connelly read a letter inviting members to attend the Third Annual A. G. DuMez Memorial Lecture on December 11 at the Health Sciences Library Auditorium. The speaker was Dr. Edward E. Smissman, Professor and Chairman of the Department of Pharmaceutical Chemistry at the University of Kansas who spoke on "Advances in Medicinal Chemistry." Dr. Lamy reported on the progress of the Sixth Annual Hospital Pharmacy Seminar Program. Miss Donna Barr of the Johns Hopkins Hospital was accepted for membership in the Society. Miss Connelly thanked Ursula Heyer and Eli Lilly for hosting and sponsoring the meeting which adjourned at 9:45 P.M.

FDA Bulletin Sent To Pharmacies

The *Current Drug Information Bulletin,* F.D.A.'s successor to the "Dear Doctor" letter, is being mailed to all pharmacies in the United States. The *Bulletin* is designed to give physicians new prescribing information and information about new drugs. The four issues that have been released since April 1970 have discussed lithium carbonate, oral contraceptives, levodopa and prescribing information for treatment of diabetes.

If any pharmacy is not receiving this *Bulletin,* it may be requested by writing to Director of Medical Communications, Bureau of Drugs, Food and Drug Administration, 5600 Fishers Lane, Rockville, Maryland 20852.

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Pharmacist Not Liable For Failing To Follow Prescription:

A California pharmacist received a prescription for propylene glycol and a cortisone cream, to be compounded into a lotion. The pharmacist failed to add the propylene glycol and dispensed only the cream. The patient filed suit against the pharmacist claiming that as a result of his error, the texture of the skin on her hands and arms changed.

The pharmacist admitted that he was negligent in omitting the ingredient but that the harm the patient suffered was not the result of his negligence. He argued that if the patient was allergic to the cortisone, the adverse reaction would have occurred even if he had dispensed the lotion, as ordered. The Alameda County Trial Court ruled in favor of the pharmacist and held that he was not liable.

This case illustrates the requirement of "proximate cause" in any negligence action. This requirement means that in addition to proving a negligent act and injury, a plaintiff-patient must also show that the injury suffered was caused by that negligent act. Negligence, without an injury flowing from the negligent act, is not a legally sufficient ground for liability.

Arkansas Court Rules That The Affixing Of A Label To An Empty Container Is Not The Practice Of Pharmacy:

The Supreme Court of Arkansas has upheld a decision of a lower court which had reversed a license revocation by the Arkansas Board of Pharmacy. The Board had revoked the licenses of two pharmacists on the grounds that they aided and abetted the unauthorized practice of pharmacy. The lower court reversed the decision of the Board and held that the activities of the employee who assisted the pharmacists in the mechanical aspects of filling a prescription did not constitute the practice of pharmacy.

The assistant would obtain refill numbers from a patient, and write this number on a receipt bag. She would then open the prescription file to the proper number and type the label. The pharmacist would then dispense the prescription, placing the label on the container himself. He would also enter the charge on the bag and place the prescription on top of it. The assistant would then place the prescription in the bag and hand it to a sales clerk who in turn would give it to the patient.

The Board had relied on an earlier case which held it to be the unauthorized practice of pharmacy for an unlicensed person to place a label on a container of a prescription medication and then hand it to the patient. The Arkansas court distinguished that case noting that in the case being considered, the pharmacist checked the label before the prescription was delivered to the patient. The court concluded that the assistant was performing only a mechanical act, even if she was placing the label on the empty container. The court proceeded to hold that the mechanical acts of the assistant cannot be construed to be the practice of pharmacy.

Possible Legal Need For Medication Profile System:

There has been discussion of late as to whether a pharmacist exposes himself to liability if he utilizes a medication record system for his patients, and then fails to discover a possible drug interaction which results in harm to the patient. A recent Nebraska case would seem to indicate that in that state at least, it may not be long before the failure to have such a system will be considered negligent.

The Nebraska Supreme Court found a hospital liable for its failure to obtain the history of a patient admitted for a maternity case. At the time of entry into the hospital the woman had a cold. Thirty-one hours after admission she died of a severe beta-hemolytic strep infection. It was later shown that the woman had a history of susceptibility to strep infections.

The Nebraska court adopted the rule that a hospital must be held liable for reasonably discoverable conditions, as well as known conditions. The court went on to say that the former requirement to render reasonable care and attention to known conditions was inadequate in that "it promotes carelessness as the less a hospital knows about a patient's condition, the safer it is against charges of negligence."

Can the same be said of a pharmacist who is not checking his patient's drug usage to prevent possible drug interactions?

Birth Control Pills:

A recent decision in Pennsylvania has held that birth control tablets were not the cause of thrombophlebitis. In a woman's action against the manufacturer of the pill, the Judge concluded that there was no reasonably demonstrated connection between the woman's taking the pills and her blood vessel inflammation. The

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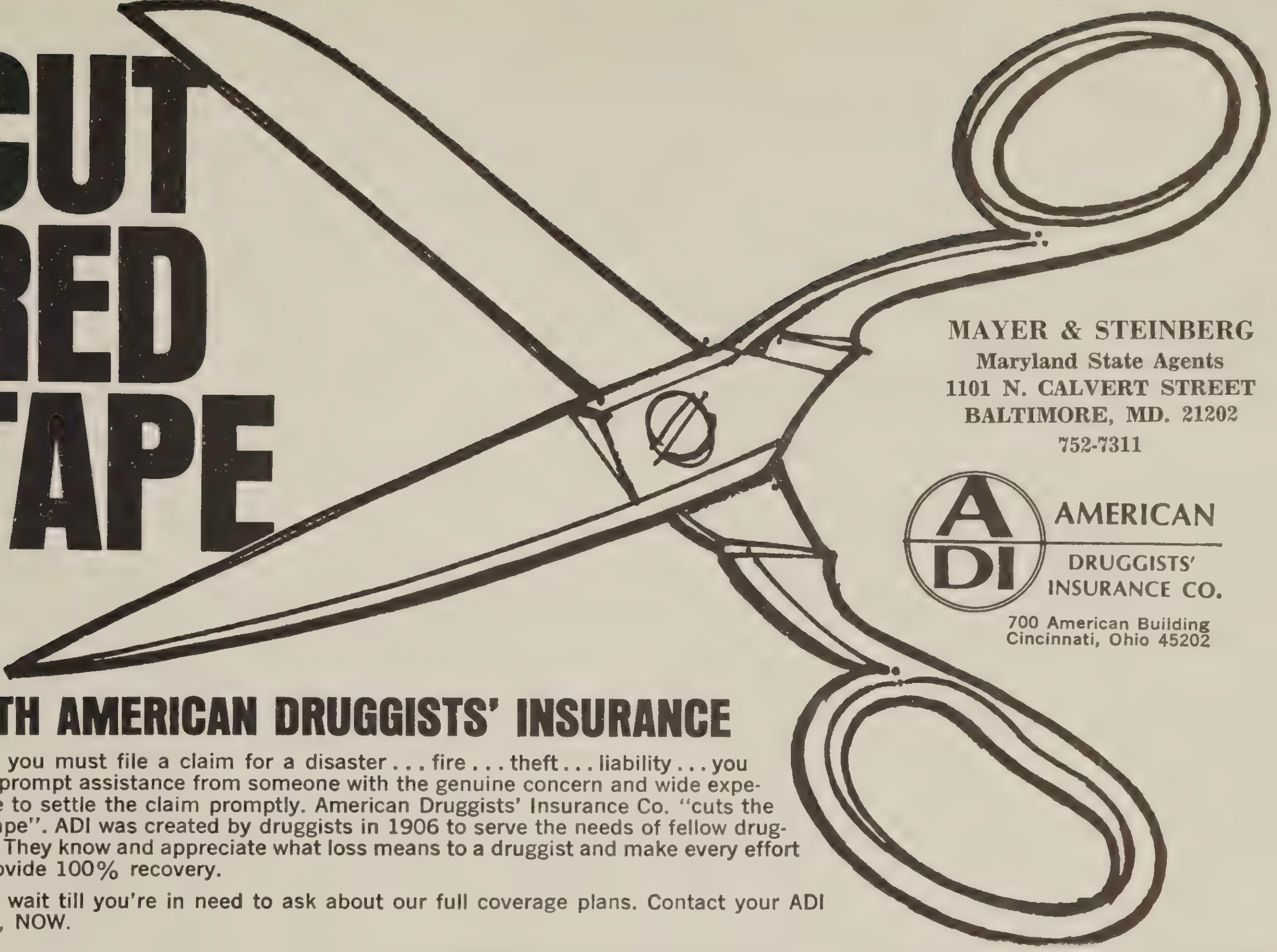
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Judge noted medical evidence that the disorder may have "spontaneous origin of unknown causes." He also relied upon medical reports that such inflammations may occur about as frequently in women who do not take oral contraceptives as it does in those who do take them.

Law Barring Contraceptives For Unmarried Women Invalid:

The U. S. Court of Appeals for the First Circuit has recently held unconstitutional a Massachusetts statute banning the exhibition, sale, or delivery of contraceptives, except as prescribed by a physician for a married person. The Court found that the statute violates the Fourteenth Amendment in that it is arbitrary and discriminatory, because of its exclusion of unmarried persons and also because it imposed certain restrictions upon married persons. The Court could see little relation between the scope of the regulation and the legislative purpose of maintaining public health. The Court was also unimpressed with the argument that it had the purpose of protecting morals, since if this were the real statutory aim of the legislation, there never was a reason to deny married couples access to contraceptives.

Drugs Obtained By Prescription Carried In Unlabeled Container:

In a recent Florida prosecution for illegal possession of Librium, which was not properly labeled to show that possession was pursuant to a valid prescription, the court upheld the provision in the statute which made such possession "prima facie evidence that the possession was unlawful." The court added, however, that this evidence may be overcome by a showing by the person in possession of the drugs that they were lawfully prescribed. The court went on to state that no other proof is required: "We recognize that valid users of the drug may lose labels, carry pills without the prescription bottle, etc., but these incidents do not render the Act arbitrary."

Artificial Sweeteners

Pharmacists should be aware that all cyclamate containing products are now banned from the marketplace as of October 1, 1970. However, the Food and Drug Administration has not recalled any remaining stocks which may be left on retail distributors shelves. The FDA has indicated, however, that the best course for a retailer to follow would be to discontinue the sale of any remaining products.

To make the situation even less sweet, there are reports that the Food and Drug Administration is considering possible restrictions on the use of saccharin. While this sweetener is currently on the GRAS list (Generally Recognized As Safe) the sharp rise in its use, since the cyclamate ban, has caused some concern.

Recently saccharin was given a "safe for use" tag by the NAS/NRC (National Academy of Sciences—National Research Council). Laboratory tests are being conducted on the safety of saccharin, in an effort to resolve the issue.

President Nixon Signs New Drug Law

On October 27, 1970, President Nixon signed into law the Comprehensive Drug Abuse Prevention and Control Act (P.L. 91-513). This new law replaces seven major federal laws governing the manufacture and distribution of narcotics and dangerous drugs and provides tighter controls in these areas. Substances are classified into five categories or schedules on the basis of potential for abuse. Other areas covered by the bill include education, research, rehabilitation, prevention and treatment of drug abuse.

Enforcement provisions of the Act are aimed primarily at pushers of illicit drugs. Penalties are lower in many cases for drug possession and higher in cases of illegal distribution. Penalties vary according to criteria established by the five schedules. For example, the penalty for distributing a small amount of marihuana for no remuneration is now the same as the penalty for simple possession of marihuana for personal use.

The Department of Justice will administer the new drug law through its Bureau of Narcotics and Dangerous Drugs. The Department of Health, Education and Welfare will be responsible for deciding which drugs should be covered by the *Act* and in which *schedule* a drug would belong. Provisions relating to enforcement and drug control will become effective May 1, 1971.

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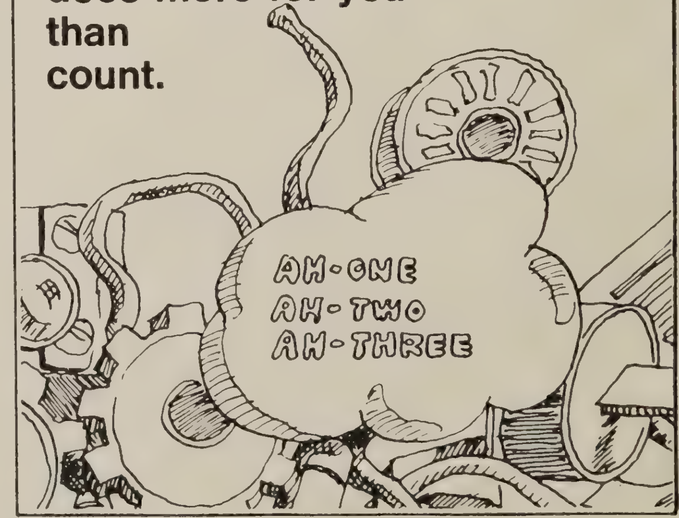

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Obituaries . . .

ARTHUR P. SHIELDS, SR.

Arthur P. Shields, 68, Catonsville pharmacist, died September 30 after a heart attack.

Dr. Shields had operated Shield's Ethical Pharmacy, now Paradise Pharmacy, on Frederick Road in Catonsville for 30 years.

He had attended the Monastery Elementary School and Mount St. Joseph High School before going to the old Milton University, where he received his Doctor of Pharmacy degree in 1930.

Dr. Shields had been a member of the MPhA, B.M.-P.A. and Wedgewood Club. He is survived by his widow, the former Margaret A. Sullivan and a son, Paul A. Shields of Atlanta.

AARON M. LIBOWITZ

Aaron M. Libowitz, 59, Baltimore pharmacist long active in pharmaceutical and health organizations, died November 17, 1970 after an illness of two months.

Mr. Libowitz was the owner of Libby's Rexall Pharmacy on Belair Road in Baltimore. A native of Baltimore, he graduated from Baltimore City College in 1928, received his Ph.G. degree from the University of Maryland School of Pharmacy in 1932 and returned to receive his B.S. degree in Pharmacy in 1936.

Mr. Libowitz was elected President of the Baltimore Metropolitan Pharmaceutical Association in 1963. He served as a member of the Executive Committee of the Maryland Pharmaceutical Association and as Chairman of the Trade Relations Committee which inaugurated the first Simon Solomon Pharmacy Economics Seminar in 1962, of which he was the Chairman.

In 1966-67 he served as President of the University of Maryland School of Pharmacy Alumni Association. For many years he was President of the Belair Road Pharmacists Council which fostered cooperative action between the pharmacists in the Belair Road area. He was also a member of the American Pharmaceutical Association and the National Association of Retail Druggists.

Mr. Libowitz was recognized for his outstanding professional window displays, receiving a number of local and national awards.

Aaron Libowitz had the distinction of being the first pharmacist elected to the Executive Board of the Maryland TB Association. He was President-elect of the Maryland Tuberculosis and Respiratory Diseases Association and had served as a member of its Board since 1962. With the Gardenville Lions Club, of which he was a member, he helped to organize the first mass tuberculosis skin testing program initiated last year in Baltimore.

His wife, the late Ida Rosen Libowitz, had been active in the Maryland Tuberculosis Association and was personally responsible for getting her husband interested in the problem.

He is survived by a son, Michael S. Libowitz of Baltimore; two daughters, Mrs. Suzanne J. Caplan, also a pharmacy graduate, of Baltimore, and Mrs. Carol R. Bulgio of New Jersey and two grandchildren.

DR. HARRY CLIFTON "CURLEY" BYRD

Dr. Harry Clifton "Curley" Byrd, former president of the University of Maryland from 1936 to 1954, died October 2 at University Hospital, Baltimore, after a long illness.

Dr. Byrd was an Honorary member of the Maryland Pharmaceutical Association and TAMPA in recognition of his many contributions to the profession of pharmacy and pharmaceutical education. Under his administration a new school of pharmacy was built on Greene Street in 1929.

His interest and cooperation helped make possible the erection of the Kelly Memorial Building, headquarters of the Maryland Pharmaceutical Association and of pharmacy in Maryland on the Baltimore campus of the professional schools of the University of Maryland.

He entered the Maryland Agricultural College at College Park to study engineering in the fall of 1905. Graduating in 1908, he then studied law at both George Washington and Georgetown.

An athletic star while at Maryland, he played end and quarterback on the football team, ran track, and played infield on the baseball team.

In 1910, Byrd went to work for the Washington Evening Star as a sports writer and at the same time became director of athletics at Western High School in Washington, D.C. He continued his newspaper work until he became President of the University.

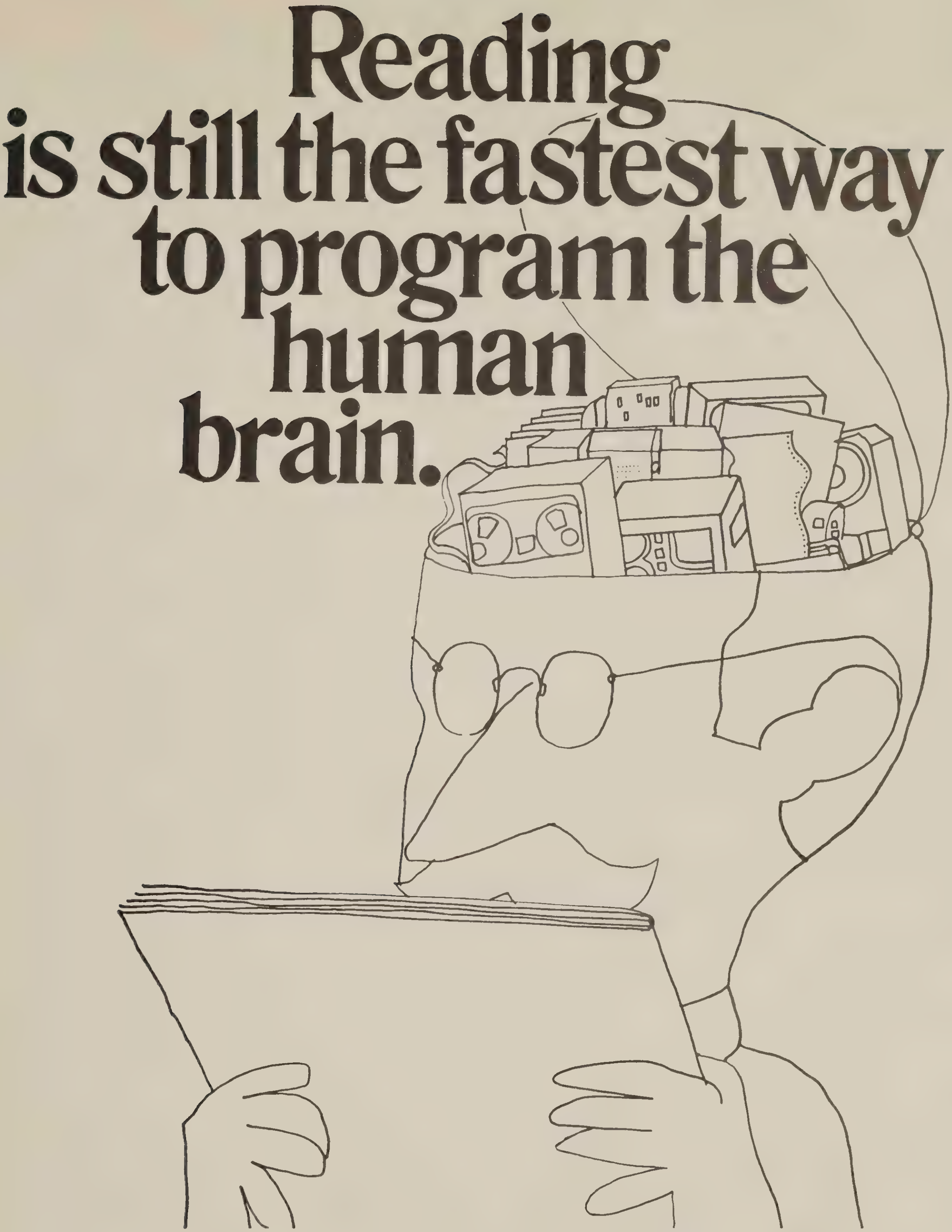
In 1912, Byrd returned to Maryland as instructor of English and football coach. In 1921, a year after the National Football League first began organized professional football, Byrd helped organize the collegiate Southern Conference.

Dr. Byrd was largely responsible for the 1920 act of the Maryland State Legislature which merged the Maryland State College of Agriculture (founded at College Park, 1856) and the University of Maryland professional schools (founded at Baltimore, 1807).

During his tenure, academic standards rose, enrollment increased some 80% and the University became noted for exciting educational experiments—and some of the finest football teams in the nation.

Many of his triumphs in the University stemmed from his activity in politics. In 1954, he resigned from the University to run for the governorship. After winning the Democratic nomination, he lost the election to Theodore R. McKeldin.

Services were held Monday in College Park at the Chapel, and Tuesday in Crisfield, Dr. Byrd's birthplace.



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